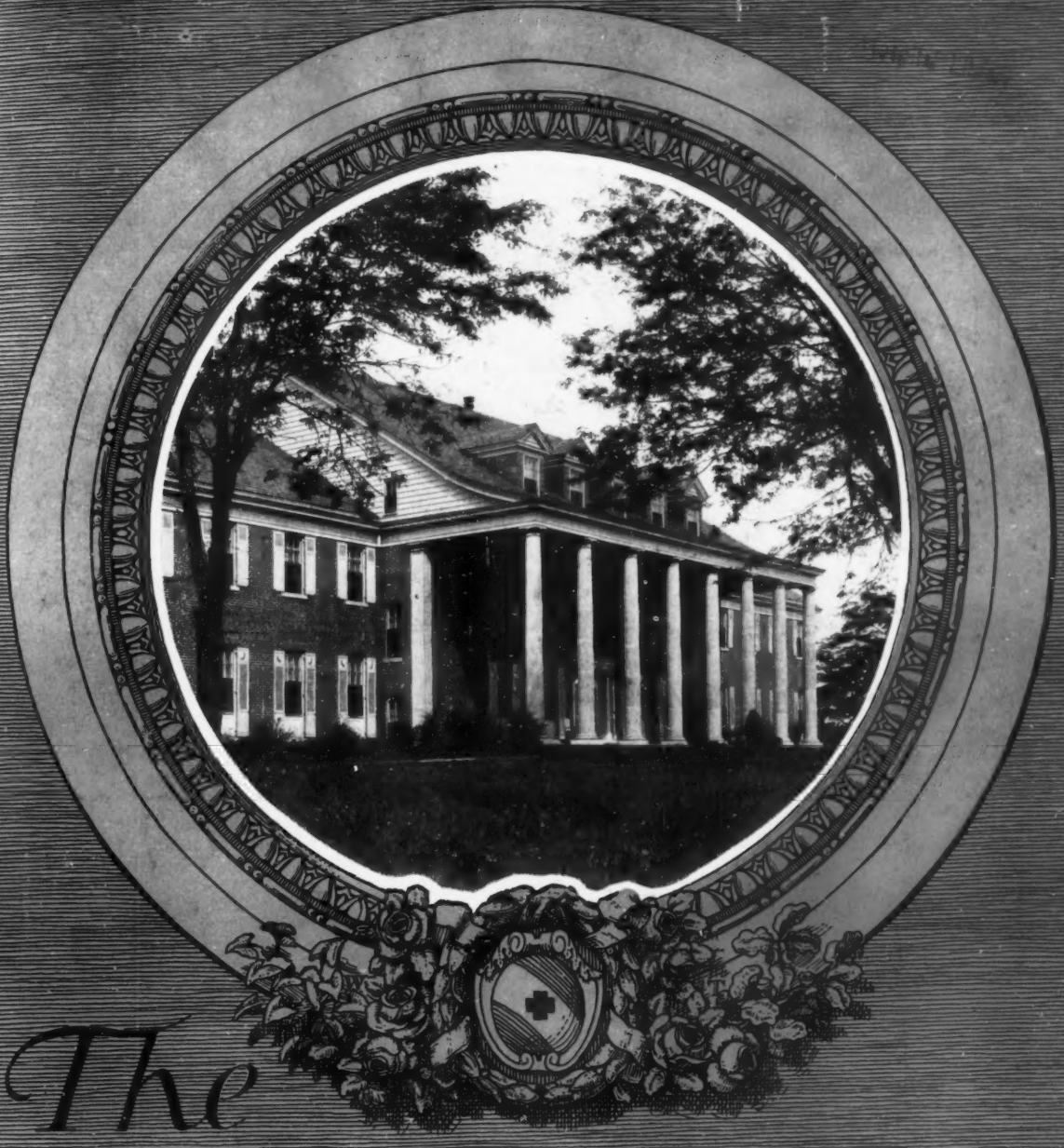
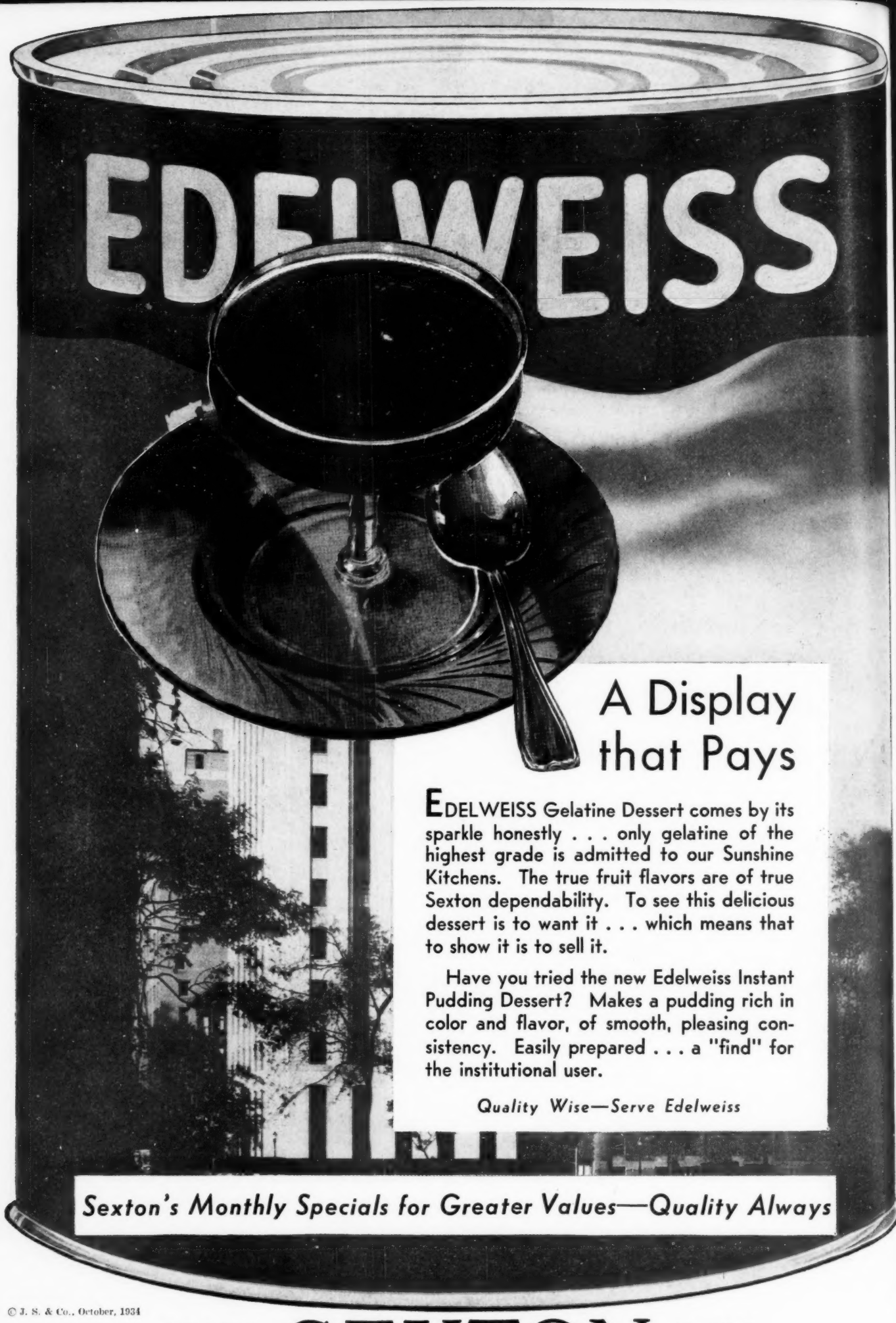


The MODERN HOSPITAL

Volume 43 NOVEMBER, 1934 No. 5



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EDELWEISS Gelatine Dessert comes by its sparkle honestly . . . only gelatine of the highest grade is admitted to our Sunshine Kitchens. The true fruit flavors are of true Sexton dependability. To see this delicious dessert is to want it . . . which means that to show it is to sell it.

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Manufacturing Wholesale Grocers

CHICAGO BROOKLYN

CONTENTS

For November, 1934

COVER PAGE—Covington Protestant Children's Home, Covington, Ky.
Samuel Hannaford & Sons, Architects, Cincinnati

ORIGINAL ARTICLES

Just in Passing—

THERE has been a shift in thinking in the FERA that has an important bearing on health work. Last year the work relief projects of the FERA were largely concerned with creating "pick and shovel" jobs such as building streets, sewers and parks. The effect of these activities was to put man power to doing jobs that machines could do as well or better and at less cost. This was doubtless justified because of the necessity for speed. But, unless we are to turn our backs on all the advantages that the use of machinery has brought us, it could not be permanent. Much of the criticism of CWA and other projects arose from this policy.

The relief authorities, of course, understood these facts and have now changed their policies to bring them more definitely in line with sound economics. They believe that their biggest task is to find new kinds of work, new occupations, that will help take the place of occupations that have disappeared because of technical advances. The greatest possibilities for new occupations seem to be in the fields of service—education, health work, recreation and similar activities. They will be receptive, therefore, to soundly conceived suggestions from hospital executives regarding needed work in the health field that can be started with relief workers and eventually become self-supporting.

A host of suggestions from hospital administrators are given in the article on page 57. If you have specific suggestions for your own community take them up with your local or state relief administrator or with the persons under the state director who are in charge of professional projects and of women's work projects. Decisions are made locally, not in Washington.

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CONTENTS

SMALL hospitals especially will be interested in C. Rufus Rorem's analysis of what hospital accounting is for and the description he gives of what the advisory committee on accounting of the A. H. A. is planning (page 37). This committee is making a special effort to prepare a standard accounting manual that will be of immediate practical help to the small hospital.

A GREAT deal of interest has been aroused in the hospital field by Doctor Ball's article in the September issue on distinguished service. The suggestions that have come in vary from small improvements in one or another part of the institution to a recasting of the whole conception of the hospital's relations to its community. More are coming in every day and they will be summarized shortly and presented to the field.

One hospital in Indianapolis has attempted to distinguish its service by "humanizing" it. The effect on the hospital accounts has been almost phenomenal. Rev. John G. Benson's account of his work appears on page 41.

PERHAPS this issue is a small hospital number. Certainly no small hospital will pass up the article on page 45. Meaty and to the point, it is written particularly for small hospitals.

IT IS not often that we have an opportunity to present an article by a male nurse. But Mr. Brown is so proud of his hospital erected for the construction gang of the Southern California Water District that he just had to tell about it. Apparently there is a real place for men nurses in such situations (page 60).

THOSE purchasing agents who are required to buy on specification will doubtless vote warm thanks to the Misses Denny and Northrop for their carefully prepared specifications for all types of hospital textiles (page 63).

A GOOD ETHER! A GOOD TECHNIQUE! A GOOD ANESTHESIA!

For over seventy-five years E. R. Squibb & Sons have manufactured for the medical profession and the hospitals a superior anesthetic Ether. In a series of advertisements for the past ten months we have suggested points of technique which have proven of value in augmenting the usefulness of a superior Ether. The following suggestions were included in the series:

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4. Some provision should be made for conserving the Ether vapor for the patient's use.
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8. Use the Ether directly from the original container.
9. Watch both eyes and use them as a guide to the stage of anesthesia.
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How are your public relations this morning? Perhaps the answer depends in part on what your telephone operator or night supervisor said to the newspaper reporter last night. In any event it might be well for you to talk over the question of the proper treatment of newsmen after you have read Mr. Faust's brief statement on page 83.

Do community chests and hospitals see their problems the same way? Can they work together in harmony or is there a fundamental cleavage in philosophy that would make it wiser for them to remain separate? Frank D. Loomis of the Chicago Community Trust will discuss this subject next month. His statements are so frank and honest that they may surprise you.

Next month also will bring a discussion of the training of interns by two physicians who know how. The Alameda County Institutions have a plan that is well worth study. Special Christmas articles will help you to plan your observance of the day. An article on the modernization of an out-patient department is another feature of the December issue.

FLASHES FROM THIS ISSUE:

"When we substituted 'elbow grease' for disinfectant and old soap, we bade good-bye to odor and it literally became the talk of the town when we lost our 'B. O.'" *Page 42.*

"The school has a picoting machine and has put a picot edge on diapers. This is less bulky than a hem, is quicker to make and is equally durable. It has been suggested that a similar finish might be used on table cloths, surgery wrappers and certain of the towels." *Page 64.*

"Large benefactions are not often made to a grocery business or to other lines of commercial endeavor. The humanitarian appeal of the free patient is the magnet that attracts dollars which, without its drawing potentialities, would be diverted elsewhere." *Page 87.*

THE MODERN HOSPITAL

THE MODERN HOSPITAL PUBLISHING CO., INC.
OTHO F. BALL, M.D., *President*
919 NORTH MICHIGAN, CHICAGO, ILLINOIS

JOSEPH C. DOANE, M.D., *Editor*
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from "Recommended Minimum Requirements for Plumbing"—published and issued by the Bureau of Standards, United States Department of Commerce.

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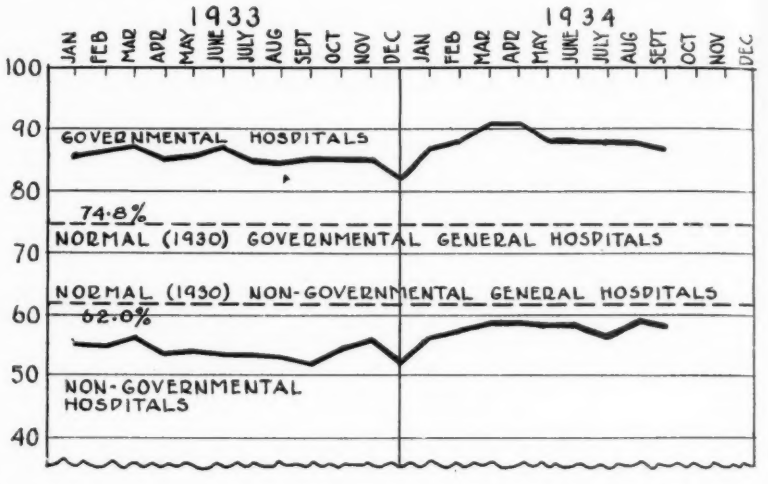
The Hospital Barometer



Occupancy in nongovernmental hospitals held in September most of the gain recorded for August and continued to show a five-point margin above the corresponding figure for last year. Governmental hospitals showed a slight decrease in occupancy, reflecting some let-up in the heavy demand for their free beds.

Twenty-one new hospital building projects were reported during the period, October 1 to 22. Of these two are nurses' homes, three are new hospitals and sixteen are additions to hospitals. Costs were reported for fourteen of the projects and total $2,230,112, making an average per project of $117,400.

Business activity declined measurably in September, according to the monthly report of the National Industrial Conference Board. The succession of downward movements in recent months wiped out advances made since last November and brought the general level of production to where it was in the second quarter of 1933. The major declines were in the automobile industry, steel and iron output, building and engineering construction (except publicly financed projects), electric power production, and textile production because of the strike. On the other hand, general distribution and trade advanced in September, although not as much as was seasonally expected in predepression years.

The decline in business activity apparently has not been shared by the hospital field, as may be seen from the data attached. Recent contacts with hospital superintendents in various states reveal a definitely optimistic feeling.

Wholesale prices as reported by the index of the *New York Journal of Commerce* declined somewhat in September and the first half of October from the high point of 79.8 reached on September 1 (1927-29=100). By October 20 the index had declined to 76.7. Grain prices, which had reached a peak of 91.7 on September 8, fell to 85.8; food in general dropped from 76.7 on September 1 to 67.8 on the 29th and then started up again reaching 69.1 on October 20. Fuel prices took an upward jump on September 22 reaching 87.4 but then declined to 82.1. Building materials dropped from 94.4 to 92.4 the middle of September and have remained there. The price index for drugs and fine chemicals reported by the *Oil, Paint and Drug Reporter* continued its long upward movement, going from 185.5 on September 10 to 187.1 on October 22.

The cost of living for industrial wage-earners advanced again in September, the National Industrial Conference Board reports, going up to 81.0 from the 79.6 of August.

Occupancy Figures of Hospitals in Various States and Cities

Type and Place	Census Data on Reporting Hospitals[1]		1933				1934								
	Hospitals	Beds[2]	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.
Nongovernmental															
New York City[3]	68	15,194	62.0	65.0	68.0	65.0	69.0	70.0	73.0	75.0	75.0	75.0*	77.0	74.0	74.0*
New Jersey	58	9,772	56.0	58.0	61.0	57.0	58.0	62.0	63.0	63.0	63.0	61.0	61.0	59.0	59.0*
Washington, D. C.	9	1,763	55.5	58.9	59.3	57.7	61.7	65.0	67.2	65.8	62.8	62.8	58.4	59.3	60.7
N. & S. Carolina	97	5,717	54.5	52.6	54.2	51.3	54.0	57.3	59.2	59.4	59.6	62.1	62.6	62.3	60.8
New Orleans	7	1,178	43.4	43.3	44.9	43.1	42.4	43.4	46.5	42.1	43.2	48.4	43.3	52.1	49.5
San Francisco[4]	15	2,825	54.3	56.3	58.1	53.9	59.5	63.0	61.9	61.6	60.3	58.1	56.8	56.9	60.8
St. Paul	7	1,128	41.0	44.7	48.8	46.0	51.8	53.8	49.4	50.7	47.3	49.1	44.9	45.7	43.4
Chicago	23	6,013	48.1	50.7	51.5	49.1	53.1	53.5	53.3	55.4	56.5	57.7	57.3	59.3	55.6
Cleveland	14	3,100	56.0	60.0	61.0	55.0	57.0	58.0	58.0	61.8	59.9	61.3	60.0	58.4	56.8*
Total[5]	298	46,690	52.3	54.4	56.3	52.6	56.3	58.4	59.1	59.4	58.6	59.5*	57.9	58.5	57.8*
Governmental															
New York City	16	11,618	101.9	103.3	106.6	104.5	100.7	100.0	105.0	103.7	101.9	93.7	91.3	89.5	88.3
New Jersey	6	2,122	87.0	86.0	88.0	82.0	89.0	94.0	93.0	91.0	90.0	86.0	85.0	80.0	80.0*
Washington, D. C.	2	1,076	85.5	83.8	87.6	87.8	87.1	88.3	83.2	84.3	84.7	84.7	79.0	80.2	81.7
N. & S. Carolina	13	1,136	55.5	58.2	56.6	50.6	58.6	65.8	66.4	66.8	64.5	69.4	70.6	66.9	64.0
New Orleans	2	2,221	122.6	111.1	105.3	96.8	106.6	112.5	129.5	136.4	127.1	137.9	148.7	152.4	152.6*
San Francisco	3	2,315						77.4	79.2	76.7	80.7	77.7	76.4	77.9	74.4
St. Paul	1	1,050	67.6	74.4	71.1	72.4	79.8	78.5	76.9	76.3	76.1	73.2	69.0	68.0	67.3
Chicago	1	3,101	77.9	80.9	81.3	80.6	92.8	94.3	93.2	94.6	91.1	87.5	84.8	83.7	83.1
Total[5]	44	24,639	85.4	85.4	85.2	82.1	87.8	88.8	90.8	91.2	89.5	88.8	88.1	87.3	86.4*

[1]Insofar as possible hospitals for tuberculous and mental patients are excluded as well as hospital departments of jails and other institutions. The census data are for the most recent month. [2]Including bassinets, in most instances. [3]Includes only general hospitals. [4]Includes only 9 hospitals with bed capacity of 1845 through November, 1933. [5]The occupancy totals are unweighted averages. These averages are used in the chart above. *Preliminary report

THE MODERN HOSPITAL

A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums

VOLUME 43 — *November, 1934* — NUMBER 5

Hospital Accounting—Tool or Torment

By C. RUFUS ROREM, C.P.A., Ph.D.

Associate Director for Medical Services, Julius Rosenwald Fund, Chicago

MONEY talks, even in hospital affairs. The accounting records describe the status and activities of a hospital, just as definitely as the nurse who reports a patient's symptoms or the physician who explains the use of an x-ray machine or the processes of a surgical operation. Accounting is the language of economic activity, and every hospital administrator should acquire a reading knowledge.

To be sure, the economic aspects of hospital service are not the only important phases of the institution. But they are inevitable aspects of hospital care. Consequently it is imperative that hospital administrators understand the significance of the economic transactions that underlie the professional services of their institutions. Accounting is a tool for controlling an enterprise involving economic transactions, and is applicable both to private business and to nonprofit institutions. Accounting is not a "mass of figures"; it is a method of classifying and interpreting a single transaction or a group of transactions.

Entries Represent Human Relationships

The accounting records are in the last analysis merely records of human relationships and activities, expressed in financial terms. For example, a nursing supervisor receives a semimonthly salary check. To the accountant this is the occasion for recording a reduction in the bank balance, and charging the "Nursing Service" with the amount of the salary. But these entries in the accounts also represent — incompletely to be sure — many hours of professional care, and the attention to innumerable details affecting the lives and health of patients.

Let us take another illustration. A check is received from the ladies' auxiliary. The bookkeeper records an increase in the bank balance and gives credit for the money received through "voluntary contributions." But the accounting entry merely epitomizes the loyalty, anxiety and labors of a group of women who have spent many hours in conducting a bazaar, soliciting contributions, or otherwise serving the institution.

The Language of Accounting

Likewise every accounting record represents human effort, classified and ultimately summarized to report and explain the activities of his institution to the administrator. The accounts cannot record the skill of a nurse, the professional judgment of a pathologist or the gratitude of a satisfied patient. But they can record the amounts paid for nursing care or laboratory service, or the amounts received from patients or other sources for these and hospital services.

Accounting, then, is not something for the hospital administrator to "leave to his bookkeeper." It is a method of control which is entirely within

the administrator's comprehension and which he should learn to understand if he is to have complete knowledge of the institution he administers on behalf of patients and the public.

A knowledge of accounting in hospital administration is as essential as knowledge of the language of a country where one travels or resides. Signs, gestures and a puzzled expression will elicit a native's concern and willingness to help, but they indicate the tourist's confusion and helplessness. The administrator should be able to discuss financial problems in the language talked by accountants, trustees, patients and contributors. There may be a few hospitals to which "money is no object," but they are as scarce as foreign countries in which everyone speaks English.

I am not advocating that every hospital administrator take his turn as bookkeeper. Nor do I suggest that superintendents give up the task of general administration and spend time in recording business transactions. But I do suggest that the accounting procedures are merely the extension of the superintendent's own activities and responsibilities. The accounting department is the telescope and microscope by which the superintendent views long-run effects and immediate influences; or — to change the metaphor — it is the camera by which he records the financial picture at a given time or a series of activities during a period of time.

We can all enjoy a motion picture without being able to operate a camera or develop a film. Likewise we can enjoy a good novel without being able to write one. But we cannot enjoy a movie or novel without some understanding of the director's "continuity" or the author's vocabulary.

Accounts Are Not for Bookkeeper's Amusement

The hospital administrator usually is able to comprehend accounting better than he realizes. Once he takes the position that the accounts are for his use and not for the amusement of the bookkeeper, he has only to ask this question. What economic facts do I need concerning my hospital? It is then the accountant's task to produce them.

There are cases in which the determination of certain facts might cost more than they are worth. But even such a conclusion involves judgment, and can be reached only after experience or careful analysis of the case. For certain purposes an administrator might ask his accountant to determine the exact costs of certain laboratory tests. If the process of determining these costs exactly proved to be very expensive, he might then decide that information concerning the costs of the laboratory services as a whole during a given period would suffice to make his decision.

The point I wish to make is merely this. The accounts have a function to perform. They are not merely an appendix to hospital service. Accounting records are adequate only to the extent they serve the administrator in the control of his own hospital.

One of the criteria of adequacy for hospital accounting is uniformity. Not all hospitals are identical. But their similarities are greater than their peculiarities. Each administrator must exercise general supervision of all departments. Likewise each institution involves dietary service, maintenance and repair of the physical plant, and the provision of certain household functions, such as laundry, linen service and housekeeping.

But a hospital is more than a hotel or rooming house. Consequently each institution must also provide professional services such as nursing, medical and surgical service, social service, medical records, x-ray, laboratory and physical therapy. The foregoing functions are common to all hospitals, large or small, general or special, urban or rural and they suffice for the classification of all hospital activities whether for in-patients or out-patients, medical or surgical cases, medical care or medical education.

Variations Do Not Affect Accounting Methods

Among hospitals there are variations. For example, one institution will serve mostly surgical cases, another will give convalescent care, and still another will accept only women's and children's cases. One hospital will employ a full-time roentgenologist, another will use the part-time services of a local specialist. One will face the problem of heating, the other of cooling. One will pay low salaries and provide maintenance of personnel, another will pay higher salaries and require or permit employees to live outside. One will have a nursing school, another will not. One will be occupied to less than half-capacity, another will have cots in the halls. Such peculiarities affect the economic problems of hospitals, but not the accounting methods by which the economic problems are portrayed and interpreted.

A uniform system of accounting will suffice to record the activities of vastly different institutions. In fact, the greater the differences among hospitals, the greater the need for uniformity in the methods of recording and reporting their business transactions. Per capita cost (cost per patient day) is the most discussed and least understood of all financial units of hospital activities. In a recent study of costs per patient day, I found that reported costs varied greatly among institutions. At first, I assumed the variations to result from peculiarities of the hospitals but found that they

were explained by peculiarities in methods of calculation.

There are two elements in cost per patient day, namely, the total cost and the number of patient days. In some hospitals total costs are interpreted to include the costs of medical education, nursing education, out-patient service, interest on borrowed funds, depreciation on plant and equipment; in others these costs are excluded. In some hospitals the calculations of patient days include the services to newborn infants, overnight guests or relatives of patients, and cases served in the emergency room; in others only adult patient days are included. Obviously, such variations in measuring cost per patient day tend to conceal the efficiency or special characteristics of the hospitals reporting the data.

The advisory committee on accounting of the American Hospital Association is at work on a manual which will suggest uniform definitions of hospital statistical and financial terms and which will recommend a standard classification of hospital assets, liabilities, capital income and expense. It will suggest also certain practical formulas for calculating income and costs of hospital departments or units of hospital service.

The manual will not be revolutionary in character; in fact it will merely codify the practices approved by careful students of hospital administration and the economics of medical service. The report is designed particularly for use in small institutions with 100 beds or less, but with a view to permitting elaboration by executives of large hospitals. Throughout the manual, and in the classification, the committee has had in mind the needs of the administrator in controlling and managing internal affairs and in adjusting the hospital to the needs of patients and the public.

A number of superintendents will say, "My hospital is peculiar and no uniform system would suit my needs." And each hospital is peculiar in certain features. Moreover the American public should be grateful for the individuality of each institution, which expresses the personality of its administrator or sponsoring agency. But individuality or peculiarity implies a comparison or contrast with other institutions, situations, locations or periods of activity. These peculiarities are revealed most effectively through a common standard of comparison or measurement. Uniform records and reports do not hamper the activities or control of individual institutions any more than a uniform musical scale interferes with the composition of a great masterpiece.

The very uniformity of accounting records and reports emphasizes the differences in hospital activities and permits of the proper control. It must be remembered that accounting data are tools made for the use of the administrator. Skillful use of them will increase the service rendered by the personnel and facilities under his direction and will justify his stewardship of community resources. For accounting is made for administrators, and not administrators for the accounts.

Rest Cure!

I'm all right. Sure I am. I'm fine, I am. I've been a little nervous but I'm all right now. I'm having a rest cure. That's what they tell me. I'm having a rest cure and I can't see anybody. Only the doctor and the day nurse and the night nurse and the floor nurse and the head nurse and the tray boys and three or four orderlies. And all I have to do is eat and sleep and not worry about anything and rest. And that's just what I'm doing.

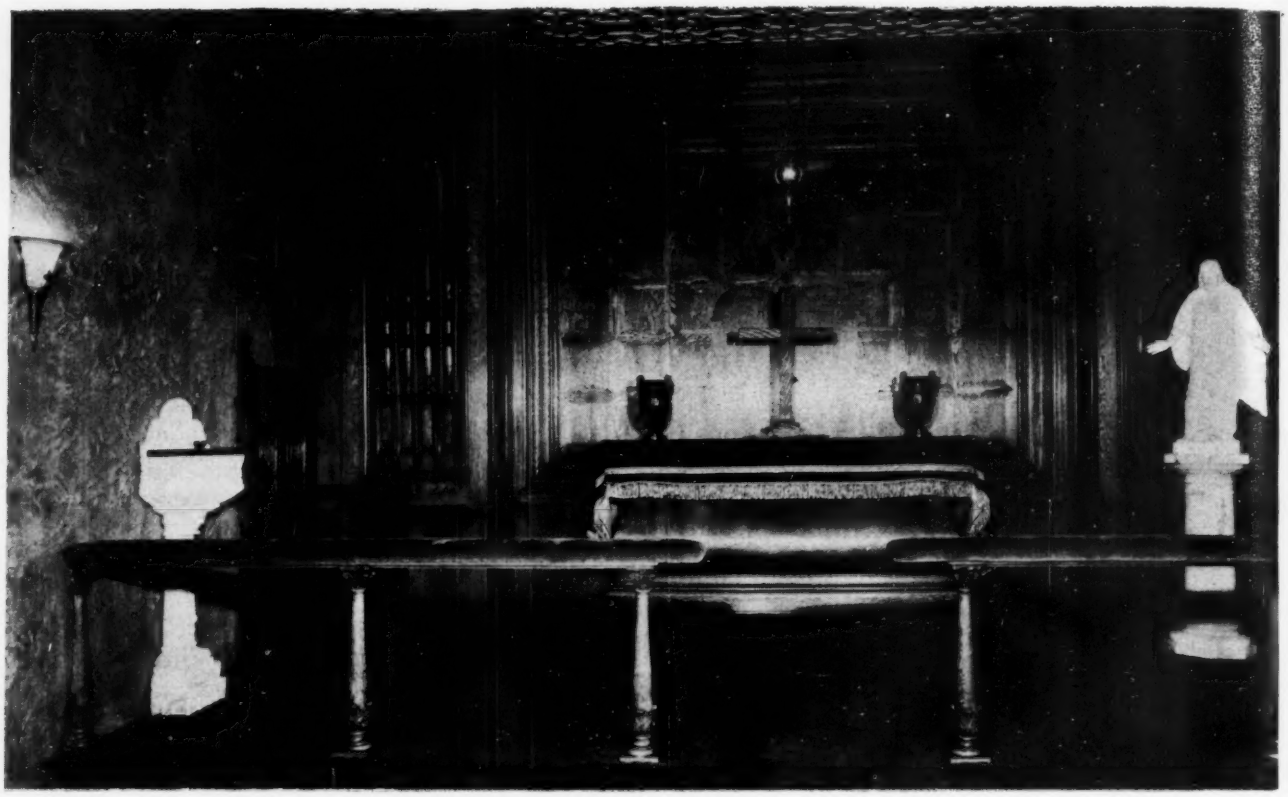
I may not look it, but that's just what I'm doing. And a hospital is just the place to do it in. No one disturbs you. Not till seven o'clock in the morning they don't. And then all they do is wash you and give you some breakfast and wash you and clean the room and then you can rest. You can till they wash the windows. And then you can rest until they want to clean the bathroom. You can rest while they clean the bathroom. You can. I can't. Not while hospitals use tin basins I can't.

Certainly I'm not jumpy. I'm fine. I like hearing tin basins banged around. And I don't mind a bit if the nurse sings while she does it. I don't mind when she tiptoes over and opens the window and tiptoes over and pulls down the shade and moves all the furniture and washes a few tin things and then goes to lunch. Well, supposing she does leave the door open. I can get up and shut it, can't I? I'm not sick, am I? I'm just in for a rest. And after I shut the door I can go fast asleep. I can till they ring the telephone. I know they have orders not to, but anyone can make mistakes. And they have to send up flowers. Even if there is a sign on the door that says "Patient Sleeping" it doesn't say "Don't wake her," does it?

I'm not complaining. After lunch I can rest. Unless the doctor comes. Well, I can rest when he goes. I ought to be able to. It's quiet here. It says so in the street: "Hospital Street Quiet." There is a little riveting next door, but who minds that? I do, but I can't stop it, can I? I can't stop progress, can I? And I can't stop the radio. It certainly was a swell idea to put radios in hospitals.

But I don't mind them, and I don't mind the visitors across the hall. They have to shout. That's cheering the patient up. They can't come in a hospital and let a patient think he's sick, can they? They have to be hearty. Sure they do. So stop biting the bedclothes. After dinner you can rest. After dinner and after your bath and after your milk of magnesia. Then you can rest. You aren't nervous, are you? You aren't going to let a little thing like a rest cure upset you, are you? Certainly I'm not. I'm calm. I'm swell. I'm not screaming. I'm resting.[1]

[1]Hospital News, from Western Pennsylvania Hospital, Pittsburgh.



The altar of a chapel dedicated to all religions and a charming nook in a parlor off the lobby, Methodist Episcopal Hospital.

Humanizing the Hospital

By REV. JOHN G. BENSON

General Superintendent,
Methodist Episcopal Hospital,
Indianapolis

Just off the lobby of this hospital is a well patronized barber shop.

THE golfer knows the significance of the term "hazards" and what they mean in his game. But all too often the hospital executive is not aware of the mental hazards the new patient encounters in finding his place in the intricacies of the modern hospital. Everything is so different. The patient himself is different; he is sick and wonders what is going to happen to him—if, when and how much? Even before he leaves home his mind has been torn by tornadoes of anxieties and he has gone to grips with mental hazards galore, until he ceases to be a normal person.

To a considerable portion of those on the outside the hospital is a complex affair hidden in a mist of prejudices, misunderstandings and painful memories. Inside, it is just as complex because of the multiplicity of organizations, wheels within wheels, and its gigantic whirl of mighty human interests. Its inner life is steeled against public feeling, insulated against human currents without, bent upon the management of its own objective.

Is it any wonder that the public dreads hospitals! Is it any wonder that hospitals are misunderstood and that memories of visits to hospitals are unpleasant!

The progressive hospital, however, is more and more being humanized and given a complexion that is communal and natural. A sick person often forms a strange notion which he cannot shake off because in coming into the hospital he finds everything from odors to noises strange, therefore unpleasant. Science has given every service it can to the sick except those simple, necessary things that would help make the patient's life as normal as it is at home. More and more we are turning our attention to touches of color and to sound and service with the thought of giving a human cast to this complex institution of healing. Since this program of taking home surroundings into the hospitals has started, going to a hospital is but little more disconcerting than going to a hotel or resort away from home or taking a walk to the neighborhood community center.

Devotion to this principle of humanizing the hospital has completely revolutionized the Methodist Episcopal Hospital, Indianapolis, after an orthodox hospital existence of more than thirty years. At first this change was greeted with ridicule and sharp criticism but now it is not only accepted but is accepted enthusiastically. "It does not seem like a hospital at all" is the phrase we hear constantly. Fine! That means that it has been made human and natural and that those who come to it for service are not given feelings of in-

feriority or do not suffer a series of brain storms.

What unearthly smells are born and continue to exist in many modern hospitals! Science has never dared to take them apart. In fact, I doubt if even science could do this trick; it would require the genius of a chemical magician. From a bit of ether through smoke (backfires from unventilated basements), to combinations from diet kitchens, garbage can, and dead-aired elevator shafts, there is one long whiff of indescribable stink that hits the new patient full force when he comes to the hospital. No wonder the poor soul is alarmed; he may know his onions, but pray what is this strange odor!

Down With the Odor!

At the Methodist Episcopal Hospital we had for years an odor the like of which never existed anywhere else. After a long search we found it was caused by a mixture of disinfectant and discarded soap used by the janitors in mopping. Many had smelled that smell so long that they thought it was the way a hospital ought to smell. We were known everywhere by our smell. It was not easy to give it up. But when we substituted "elbow grease" for disinfectant and old soap, we bade good-bye to odor and it literally became the talk of the town when we lost our "B. O."

With the slaying of the old odor we substituted a delightful deodorant, pleasant to the nostrils and suggestive of spring flowers, so that the first suggestion to the patient upon entering the hospital is sweet and delightful. For good-will building miles of newspaper accounts could not equal the results of the extinguishing of a bad odor.

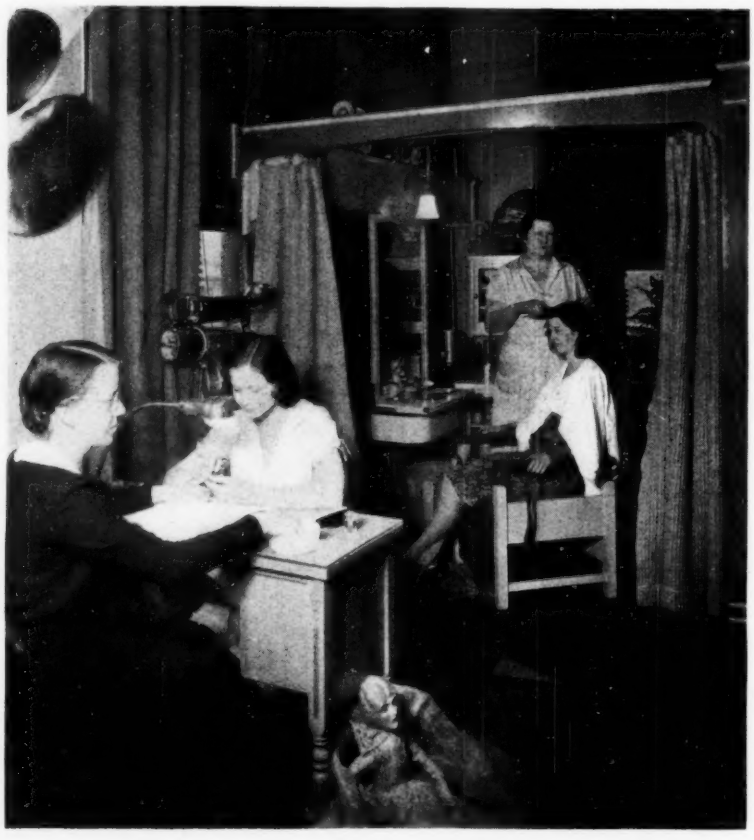
A Lively Lobby

It is important that the air not only be clean and sweet but that it be charged with hospitality and efficiency and everywhere give evidence of life. Thank goodness, color has found its way into the modern hospital, and artistry—no more expensive than stupidity—has taken its place in hospitals all over the land.

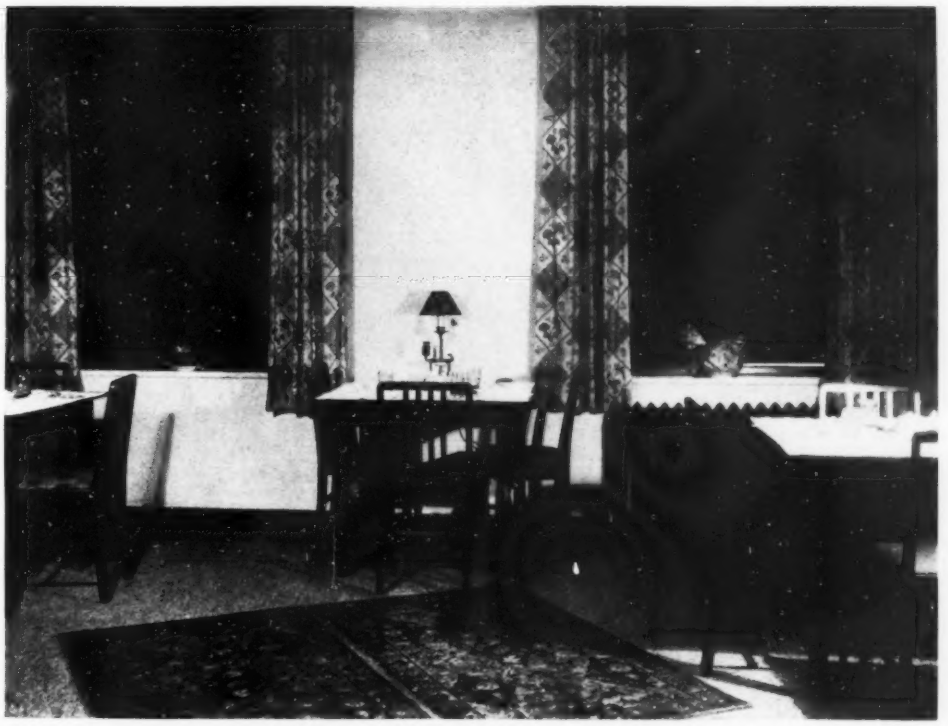
The lobby at our hospital was for years repulsive, crude and ugly, as well as smelly. A good angel who long had wanted to do something furnished funds to bring the drug store up out of the basement and to set it down with soda fountain, magazines and whatnots right where it greeted the public. Room was provided for waiting patients and friends to sit down and visit, have refreshments or read. It not only helped to humanize the lobby but it helped in the terrible days of the depression to earn extra nickels for the cause. Our drug store nets more than a thousand dollars a month for our current fund.

A service that has been of help in creating good-will has been our guest department, or hotel division, including a beautiful public tea room just off the lobby. Here those who want to be near loved ones can find rooms at moderate prices and a well run tea room. There is nothing about this department that smacks or smells of a hospital and yet is a part of the hospital lobby and furnishes happy comfortable surroundings for anxious folk who want to remain near. Thrilling stories could be told of what this department has meant when serious reactions have suddenly come. Visiting doctors make continued use of this department and find it a convenience. We have found it decidedly profitable, for it has netted more than $600 a month during its two years' existence. But, best of all, it is another step toward that objective of humanizing the hospital. "Why, with your hotel and tea room it does not seem like a hospital." More good-will and some good money to help keep the superintendent's hair from turning gray.

"Well, what do you think of that? A barber shop and a beauty parlor."



The beauty shop makes a therapeutic contribution.



A cheerful dining room for guests is also a public tea room. It brings the hospital both good will and good money.

Yes, they have them elsewhere, why not in the hospital! Life should be as nearly normal in a hospital as it is elsewhere, and if barber shop and beauty parlor are helpful, why not have them? Two barbers and two beauty shop operators are kept busy in our hospital. They make good money and the hospital shares these monetary returns as well as the service benefits. A good barber and a cheerful, efficient beautician can make a therapeutic contribution to the restoration of the patient.

A Chapel and a Library

In going to the hospital the patient takes his heart and his head with him. Therefore, in our lobby there are a chapel and a library. Our hospital was fortunate in having plenty of space to make this lobby arrangement, but other lobbies can express in other ways social and human harmony that will produce the same effect.

A beautiful small chapel is finished in dark oak and has heavy carpet, memorial windows, an altar with symbols of the great major religions, an eternal altar light burning, and Thorvaldsen's figure of the Serving Christ carved out of white Carrara marble. The chapel, dedicated to all religions, greets the new patient on the way from the lobby to his room. It is there also for spiritual rendezvous for convalescent patients or visiting friends. A post card is sent off the day of admittance to rabbi, preacher, or priest, notifying him of the admittance of one of his flock. Thus the social ties that sustain a person in his normal communal relations are not severed because he has come to the hospital.

The hospital library also is in the lobby and a charming librarian teases sick and convalescents with literary menus ranging from fiction to still more fiction. Here near the lobby parlor with beautifully upholstered chairs, gracious lamps and striking pictures is the hospital library with books, magazines and pictures everywhere, affording an inspiration to the convalescent who is wheeled in for a brief visit. About the hospital are other de luxe rooms fitted with carpets, lovely draperies, pictures and all that is to be found in the best of homes. Well, why not? The home really ought to be taken into the hospital.

Many hospitals have far more beautiful lobbies than ours. The only point with us is that after our hospital was built we had to reconstruct a lobby to promote the psychological attitude that a person needs who is facing a stay with pain. First impressions are lasting and we are endeavoring to help every one who comes to us to feel at home.

The Folk at the Front Door

We have not mentioned the personality of the folk at the front door. If we had to choose between furniture, pictures and other physical attractions, and the right person at the front door or anywhere else in the hospital, we should always vote for the personality. To give a personal touch to our lobby, we have a bright, attractive person at the information desk to greet the public. Neatly uniformed bell boys are at her command to escort the patient immediately to the room, to answer questions and to give assistance to those who do not seem to know just what to do or where to go. All this is a vital part of the lobby picture. The humanized lobby builds good-will, an invaluable asset.

Someone Has Asked—

Should Practical Nurses Care for Hospital Patients?

The pressure to allow practical nurses to do institutional work is growing daily. More militant members of the various cults demand that the community hospital open its doors to them.

Most institutions have ignored these requests. Here and there one finds individuals of high idealism and considerable skill who are not qualified by law to practice medicine, nursing or any of the other branches of the healing arts. Yet they are capable of rendering a good grade of medical service in a narrow field. On the other hand, hospitals that desire to be recognized by national medical and nursing associations and by state boards of medical education must of necessity refuse to allow such persons to attend patients.

The American Medical Association insists that a hospital which it approves for the training of interns shall provide registered nurses who are graduates of schools of nursing recognized by the state board of nurse examiners. When undergraduates are being trained they should be supervised by registered graduates in nursing.

The practical nurse might serve in the hospital as a nurse attendant under the direct supervision of a graduate nurse. The former should not and cannot be permitted the responsibilities and prerogatives of one who possesses a degree in nursing.

Should Information Concerning Patients Be Given by Mail?

Requests for information relative to diagnoses or results of laboratory studies frequently reach the superintendent in his daily mail. Many are couched in phrases that indicate a genuine interest in the patient's welfare.

Queries from legitimate charitable organizations or from social service departments of other hospitals are of course answered. But when an individual requests facts concerning a patient great caution should be exercised. Many institutions that refuse to give diagnoses by telephone do not hesitate to do so by letter. Inquiries as to the result of a Wassermann reaction or a vaginal smear or questions regarding any personal or social data should not be answered through the mails.

A personal interview is perhaps a safer procedure but even this method of giving out information is often dangerous to some innocent person. Perhaps the best plan to adopt is to insist on the presence or the written authorization of the patient before any facts whatsoever concerning his diagnosis or treatment are given. It is the first obligation of the hospital to protect every interest of its patients.

To Which Department Should Syphilis Cases Be Assigned?

This question frequently arises among the members of the hospital staff. The dermatologist is insisting with increasing frequency that syphilis with cutaneous manifestations be assigned to him. The genito-urinary surgeon believes that this condition rightfully should be treated in his dispensary and wards. At times where there is a danger of creating ill feeling between these two groups, a compromise is adopted whereby all patients suffering with syphilis without a skin rash are assigned to the genito-urinary surgeon and those who are first seen in the dermatologic clinic because of some skin lesion are retained there for treatment.

It does not appear wise to indulge in hairsplitting in the solution of any hospital problem in an endeavor to please every staff physician. On the other hand, syphilis presents such a great variety of manifestations affecting the cardiovascular system, the joints, the nervous system, and the genito-urinary system that some institutional policy should be adopted in regard to its treatment.

Perhaps it would be wise to consider the formation of a group to which the treatment of syphilis in all of its forms could be referred. This group might consist of an internist, a genito-urinary surgeon, a dermatologist and perhaps a laboratorian. A decision could be made by this group as to the department to which the individual case should rightfully be referred. In ward cases in which cardiovascular syphilis is encountered, the internist on duty could request therapeutic advice from this group should he consider it necessary.

Certainly syphilis is no more a skin disease than scarlet fever and hence it should not be wholly assigned to the dermatologist. If no better solution can be reached, the supervision of the genito-urinary clinic and ward service should be in the hands of the genito-urinary surgeon.

Are There Too Many Blood Transfusions Performed?

The transference of blood from the well to the sick has in some localities become a veritable fetish. All types of conditions ranging from minor complaints to diseases capable of quickly terminating life are treated by the transfusion of blood. As a result, the hospital superintendent is often importuned to provide money to supply this remedy, and in some instances this expense runs into many hundreds of dollars annually.

A lay superintendent naturally hesitates to deny a patient the benefit of a remedy that physicians contend will be beneficial. This is particularly true when the request for blood assumes the proportions of an emergency, a classification often undeserved.

A small emergency fund might be set aside for the purchase of blood for indigent patients. A staff committee might be requested to formulate a routine to control this troublesome matter. When a medical administrator is at hand he can often judge as to the validity of the staff physician's request. On the other hand, a firm insistence by the executive that only in emergency cases will this expense be borne by the hospital is frequently effective. Particularly is this practice to be condemned when it is employed by an unethical physician to shield himself from blame when the patient approaches death.

The pendulum will, no doubt, swing backward in measuring the popularity and worth of blood transfusions and the public, recognizing the method's limitations, will be less likely to demand blood transfusions in hopeless cases.

If you have any questions to ask, the editor will be glad to discuss these in a forthcoming issue

The Small Hospital and Its Medical Staff Relationships*

By REV. H. J. WRIGHT
Chairman, Committee on Small Hospitals, Canadian Hospital Council, Inverness, N. S.

THE relationship of the medical staff to the small hospital differs greatly from that of the staff of the large hospital where organization is perfected to a greater degree. Small hospitals must be open hospitals and at once the question of the status of doctors from near-by towns or villages arises.

Sometimes one doctor dominates the situation and staff organization is almost impossible. Small hospitals find it difficult to hold staff meetings, and this in turn makes it more difficult for the hospital to enforce the keeping of records and at times introduce a new element into the question of the relation between the medical staff and the superintendent. Often the hospital is called upon to lend supplies and perform various services such as sterilization of gloves for local doctors. At times this is at some expense to the hospital itself and must be done with some judgment.

Five questions are raised and answered in this paper. (1) In the small hospital, which shall it be—the open or the closed staff? (2) How can full attendance at staff meetings be reconciled with country calls and night work? (3) What plan of keeping medical records will gain the widest cooperation from the doctors? (4) What courtesies may the hospital extend its staff men? (5) How can the relations between medical staff and board of trustees be kept cordial?

No one answer to any of the foregoing problems can be made dogmatically. The human element enters in so largely and counts for so much that each locality and hospital must work out its own solution. But situations become typical and the following suggestions which may be used as guiding principles will tend to show how a few people at least have met and solved some of the points raised.

Open Versus *Closed Staffs*

G. H. Murphy, minister of health for Nova Scotia, makes the following comments on the question of open or closed staff:

"The practice of so-called open and closed hospitals seems to have arisen largely out of a community effort to give adequate medical attention to the sick poor.

"In the small hospital the doctors, whether in town or in the surrounding country, who send patients to the hospital, should constitute the staff. All have a common interest. It should be insisted upon, however, that if the doctor from outside the town lives at too great a distance to care adequately for his sick patient and to be within reasonable reach of the hospital in case of an emergency, he should place that patient's care under the direction of some doctor living near the hospital. It is most unwise, on the surface at any rate, to make any other discrimination. When one doctor dominates the situation so far as other doctors are concerned, I think the best plan is to let him dominate. The hospital management would be well advised to gain his confidence and through his undoubted influence with the other medical men, seek to improve the medical service of the hospital."

From the standpoint of the superintendent we have two opinions respecting open or closed staffs. Both come from superintendents of small hospitals in Ontario. The first statement follows:

*Adapted from a report prepared by the committee. The other members are Rev. Mother Audet, R.N., Hotel Dieu Hospital, Campbellton, N. B.; Dr. G. Harvey Agnew, Canadian Medical Association, Toronto, Ont.; Dr. F. E. Coy, Invermere, B. C.; Mrs. P. M. Fielding, Payzant Memorial Hospital, Windsor, N. S.; Mrs. O. Findlay, Municipal Hospital, Red Deer, Alta.; Miss H. E. Hivey, R. N., Miramichi Hospital, Newcastle, N. B.; Florence Hodgson, R.N., Cottage Hospital, Pembroke, Ont.; Dr. F. W. Jackson, Department of Health, Winnipeg, Man.; W. H. McCulloch, Souris and Glenwood Memorial Hospital, Souris, Man., and Dr. F. W. Routley, Ontario Red Cross Society, Toronto, Ont.

"In small communities there should be open hospitals. Doctors from neighboring towns and villages should have the same status as local men, provided they have the proper credentials, are licensed to practice and are members in good standing in the profession. Usually in small hospitals one or two doctors have a larger number of patients than the others. No doctor should receive more attention from the nursing staff or be granted more privileges from the board than another. The greatest consideration should be shown all cases for doctors and nurses exist for patients. With the least fuss, each member of the medical profession should receive his share of attention."

Argues for a Closed Staff

The contrary opinion is expressed by the second administrator: "It is not necessary for a small hospital to be an open hospital. We have a medical staff of six doctors appointed by the hospital board. The medical staff holds at least ten staff meetings a year and follows the rules laid down by the American College of Surgeons. If a doctor not on the staff brings a patient from an outside district, he is permitted to assist one of the doctors on the staff at any operation."

It is obvious that some word regarding the question of open or closed staff must rest with the board of trustees. The following comments are from Mrs. P. M. Fielding, for many years an active member of the board of Payzant Memorial Hospital, Windsor, N. S.:

"In small hospitals the medical staff should always be consulted before a rule is made allowing doctors from other towns to come in and have the same status as the men on the roster. If the visiting doctors are allowed the privilege they should be willing to take their regular monthly work of caring for the free patients. No one doctor should be allowed to dominate in any hospital. Better be without his services. This state can be, and should be, dealt with by the medical staff, which is organized under by-laws and regulations."

Doctors who have not had a country practice may not understand how difficult it is to hold staff meetings. The difficulties of organization are: (1) no one doctor is willing to take the initiative; (2) country calls or night work leave the doctor no definite hours for planning meetings; (3) distances make it impossible for large representation at meetings; (4) the public is not properly educated to the advantages that organized medical staffs can provide, and (5) petty jealousies are likely to exist.

That the problem has been successfully solved in many places is common knowledge and that doctors and hospitals have benefited no one will dispute. The following from G. H. Murphy of Nova Scotia sets forth the situation in one district in New Brunswick:

"It is a generally recognized principle that staff meetings in a small hospital are most satisfactorily held once a month. Where some doctors come from the surrounding country, a certain day could be chosen and the courtesy of the hospital extended by giving the few men who gather a midday meal or supper. Before or after this they could meet and discuss their mutual problems with particular reference to their work in the hospital. As an example of what may be done, there is a small hospital in Tracadie, N. B., with a staff of four doctors. One doctor lives in the village, one fifteen miles away, one forty miles away and the fourth seventy-three miles distant. During the summer months these men meet regularly each month. In the winter the man in the village and his nearest confrere meet monthly as before, along with the superintendent of the hospital and the senior nurses. Careful minutes are kept and the meetings are regarded by the doctors as invaluable."

From Ontario we have the following suggestions to meet conditions less drastic than those in more isolated sections:

"Each month something different to attract the busy doctor should be planned. One district has an annual picnic in July to the summer home of one of the doctors and the meeting is held there. One hospital has a luncheon on Monday when doctors from rural districts send in referred work. Most of the men are able to meet at lunch hour. Another hospital staff has a banquet each winter held shortly after trains come in from the surrounding district. After the meeting a social hour is held."

Recommends an Active Program Committee

Dr. G. Harvey Agnew writes as follows:

"One major reason for lack of interest in staff meetings is the lack of preparation in the program. There should be an active program committee which will prepare in advance the details for the meeting. A mere reading of the deaths for the month is not sufficient. The more interesting ones should be picked out for special discussion; the doctors in charge should be especially notified; other doctors interested in those diseases or holding contrary views as to treatment should be requested to come prepared to discuss the cases; specimens, slides or even textbook illustrations should be laid out to clarify the discussion. It is most essential to develop a general staff

willingness to discuss diagnoses and treatments freely and without reservation and to develop a general confidence that frank criticism or disagreement is possible among the closest friends and will not be misinterpreted or carried beyond the four walls of the place of meeting.

"There is greater reluctance to discuss clinical cases or to present patients at staff meetings in small hospitals than in larger institutions. Where there is a dearth of clinical cases or data some staffs have solved the problem by holding evenings partially devoted to cultural pursuits. Some good historical nights have been developed and much valuable local historical data unearthed by this procedure."

The big difficulty of organization is that someone must take the initiative. Why should not the board of trustees call the doctors together for organization?

Keeping Proper Medical Records

The importance and difficulty of keeping proper records crop up continually. Suggestions for solutions are set out by four men.

A member of a board of trustees frankly puts the matter on the shoulders of the superintendent. He says: "The superintendent is the best person to keep the doctors up to the mark in the matter of records. This should be insisted upon by the board if the medical staff is lax in the matter of medical histories of patients. Many vital issues depend on these being well and accurately filed in the archives of the hospitals."

A superintendent realizes the various aspects of the question. He says: "It is often difficult to secure proper keeping of records because (1) there are no interns to admit the patients; (2) there is no competent secretary possessing a knowledge of anatomy and medicine as well as bookkeeping; (3) the doctor sending in the case may not refer the case to a town resident doctor, his visits may be at night or at times unsuitable for history taking, and (4) the doctors keep telling you they will take the history but fail to do so until the patient is almost ready to be, or has been, discharged."

The suggestions of another superintendent, equally to the point, are: "The hospital can best insist on this by (1) informing each member of the staff that unless he is willing to cooperate and fulfill his duties he is the cause of the institution's not being standardized; (2) by supplying the staff with a nurse who has had special training and will keep the records in good condition and available for doctor's services at all times; (3) if the medical staff is properly organized the doctor failing to keep records can be dealt with and a decision made by the board, and (4) the hospital board may have in its constitution a clause relative to the problem."

A doctor who has had wide experience in a small hospital in an industrial area, then in a city hospital and later as a minister of health for one of the provinces, says:

"The keeping of records in a hospital requires but one single prerequisite. That is the desire of the doctors themselves to keep good records; ultimately this is the physician's responsibility. In every way it is to his advantage. In small hospitals, particularly, the doctors plead, and often with justice, that they are too busy. By adopting a system that requires little actual handwriting and by assisting the doctor by providing a nurse to make the daily rounds with him and to take notes on the charts which he may wish to dictate to her, fairly adequate reports may be secured. As the system develops, its value to the doctor becomes increasingly evident to him and early hesitation turns to enthusiastic support. Insistence on the part of the small community hospital is unwise from the point of view of discipline. Insistence should be replaced by persistence on the part of the hospital superintendent and supervisors. After a time less persistence is required but constant reminders get the best results."

The subject of courtesies is bigger than the occasional act to oblige a doctor. The reaction on the hospital is one that can well be considered in connection with public relations. For the following suggestions, we draw from the views of a number of trustees, superintendents and doctors. Those views have been selected which typify the opinion of the group as a whole.

Courtesies That May Be Extended to Staff

"It is always advisable," says a trustee, "to extend courtesy to staff physicians in the matter of sterilization, gloves and lending of splints, but the superintendent should always keep a strict record of articles and dressings used in practice outside the hospital, collecting the cost of them if they are not returned."

"I believe," says a superintendent, "it is advisable to extend courtesy to local doctors by (1) sterilization of packs, drains, gloves and supplies; (2) lending crutches, splints and special treatment articles; (3) doing outdoor dressings when necessary where no outdoor service is maintained, and (4) sending out graduates for experience to assist with deliveries in the poorer homes, assisting both patient and doctors as well as gaining personal experience. The reward the hospital receives for such courtesy extended is the good will of the medical profession and the community.

The satisfied patient and doctor are the best recommendations the hospital can have."

"The hospital may, if it wishes," says a doctor, "make provision that the little courtesies will be extended only to those doctors who keep their records up to date. The medical man, particularly with a large country practice, deeply appreciates such aids to his practice, but I think he should be made, in one way or another, to understand his obligations toward the hospital for this service. Such services are often appreciated more if the doctor, for example, is asked to purchase his own gauze and absorbent cotton, even make up his own dressings, the hospital doing him the favor of sterilizing these goods. In this way only can he be taught the value of these articles, and economy thus learned in his own practice is generally carried out in the hospital itself.

"In the same manner splints may be lent if there is not too great a depletion in the supply caused by such loans. When such a loan is made, even to the poorest patient, a small amount should be left with the hospital as an earnest of its care while in use and of its safe return. The whole situation in any small hospital is one that must be treated with sympathetic cooperation between the medical men and the hospital management."

The matter of the board must be included here as the connecting link between the medical staff and the superintendent. The position taken in the following statement may be regarded by some as rather extreme insofar as it concerns the board and the medical staff, and its adoption would make the superintendent, and not the board, the connecting link.

Superintendent Acts as Go-Between

"The superintendent should act as the go-between for the board and the medical staff and should attend all board meetings. Everything should go through the superintendent and there should be no direct dealings between the board and the medical staff either as a body or as individuals. Unless both bodies have confidence in the superintendent it will lead to endless bickering and the superintendent had better retire."

It is worthy of note that the foregoing statement is from a medical man. Another doctor says:

"I believe the board of any general hospital should have among its members representatives from the medical staff and that the superintendent should at least be an ex officio member of the board and his attendance at the meetings compulsory unless his work is to be discussed."

There are many who would eliminate the word "unless" and say "especially when," and thus alter the meaning of the last sentence.

The following viewpoint of a superintendent is equally important and perhaps gives more consideration to the human element:

"Have an occasional meeting with the trustee and medical boards and serve them lunch. In order to establish efficient management mutual confidence should exist between the board and the superintendent. Hospital boards usually consist of business men who probably know all about the financial end but have little knowledge of the internal management of the hospital. If the superintendent attends the board meetings for part of the time at least the members can assist her and she can appeal to the board for information and instruction and make any suggestions necessary for the improvement of the hospital."

Four Suggestions for Improved Relationships

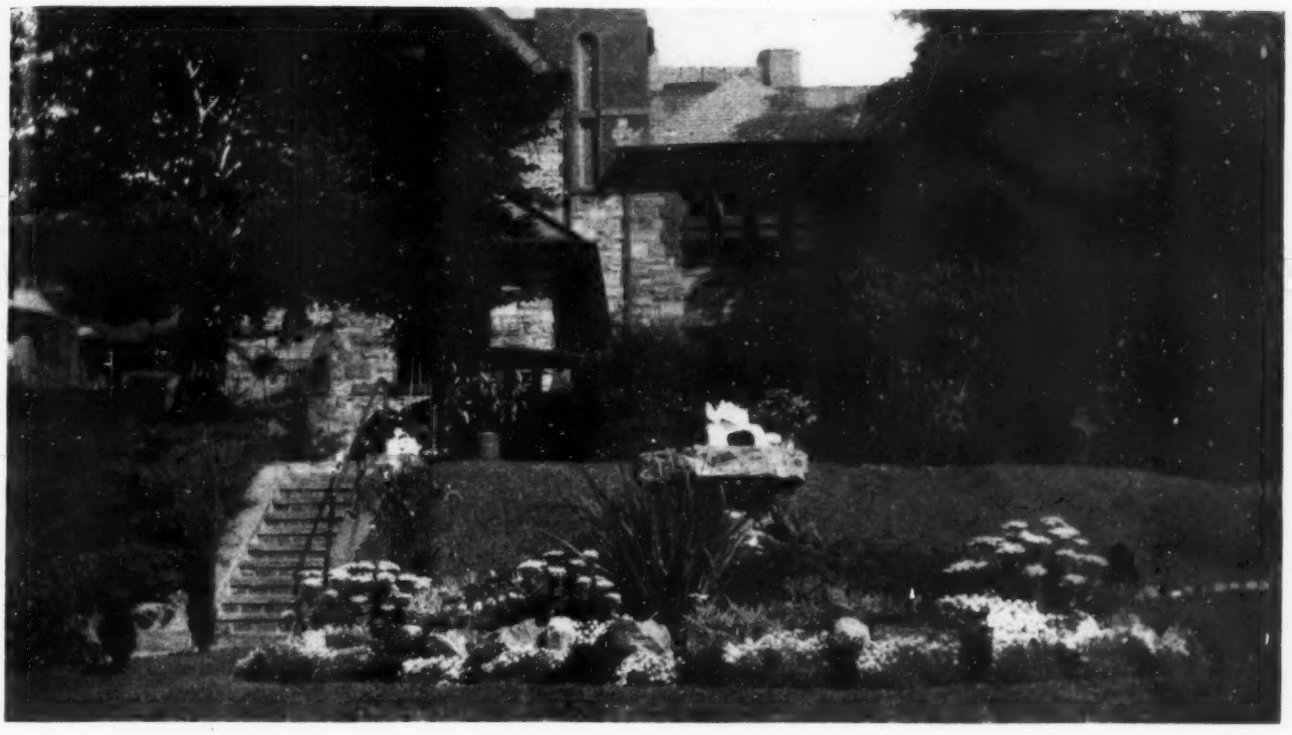
Another superintendent offers the following suggestions as conducive to a satisfactory relationship: (1) all complaints from or respecting members of the medical staff should be in writing directly to the medical staff executives; (2) all complaints regarding the superintendent should be sent in writing to the superintendent; (3) the superintendent or staff members should be given full opportunity to defend themselves, and (4) requests from the medical staff to the trustee board should go through the superintendent.

That a large element of mutual understanding must enter into the position must be continually remembered. An objective worthy of earnest effort is well expressed by a trustee:

"Trustees with judgment and some knowledge of hospital matters, of the care of patients, of the value of proper expenditure and of the characteristics of the medical profession may work wonders for the well-being of hospitals. With these qualities fairly well balanced in a board, a qualified superintendent and a medical staff with an outlook extending beyond their own immediate sphere of usefulness, there should be no trouble. To say that a superintendent should be compelled to attend board meetings would be unreasonable. There should be no hesitation on the part of the superintendent to attend if required, but these matters are best left to the individual hospital."

Visiting Hours in Small Hospitals

Rigid visiting hours cannot be observed in the small community hospital because train connections do not always coincide with visiting hours, visitors frequently come long distances by motor and cannot arrive at set hours, and farmers cannot get to town until after the evening chores are done. Rules for visiting can be enforced for persons living near the hospital, but exceptions will have to be made for rural visitors in order to retain their good will.



Little Things That Count in St. John's Riverside

Unlike others in this series of Little Journeys, our trip to St. John's Riverside Hospital, Yonkers, N. Y., starts in a room in the basement that might well be known as a laboratory of practical ideas. Too many details that contribute to efficiency in hospital routine pass unnoticed. This time with the aid of pad and pencil, many have been noted in their application to different parts of the institution

By RAYMOND P. SLOAN
Associate Editor, The MODERN HOSPITAL

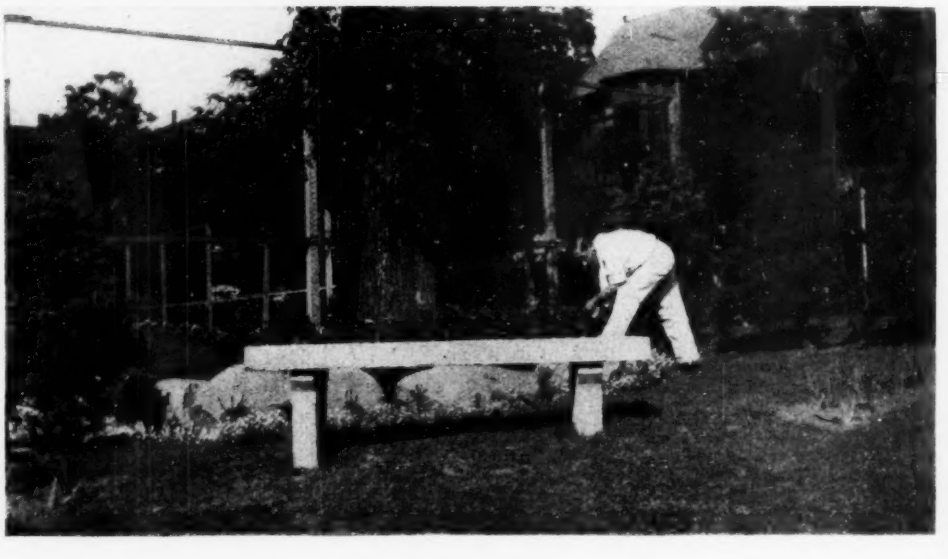
THE journey has but started once you leave the glistening, rippling Hudson River at the station of Yonkers and ascend the steep slopes to the crest of the hill where stand two gateposts bearing the name, St. John's Riverside. Only a half hour from the center of New York City, to be sure. It seems incredible, so marked is the contrast from the tumultuous metropolis to this sunny town with its own substantial business center perched on the river's very banks. A little metropolis of its own, yet still retaining much of its original charm as a hill town of Westchester County.

The approach to the hospital property with its terraced gardens coming down to meet you at the main road marks the real beginning of this little excursion. Indeed, it requires considerable care to differentiate its entrance from the driveways of certain vast estates of which the community can justifiably boast. The original building hugging the hill hides its institutional lineage behind latticed windows and huge trees. In sharp contrast the modern brick building which it adjoins stands as in utter defiance openly proclaiming to the world at large its powers to perform miracles through providing modern hospitalization.

At the main entrance, reached from the street by a circuitous pathway along beds filled with flowers ranging from the gay tulips of early spring

From the tulips of early spring to the tawny chrysanthemums of late fall, the gardens are a mass of color.

When not in his office Captain Warfield is generally to be found in carpenter shop or garden. The direct relationship between the two is evidenced in the garden bench, a product of the workshop.



to the tawny, hardy chrysanthemums of late fall, is the first indication that it is the little things that count in St. John's. Space has been provided at the left of the front door for a playground for children.

To discourage visitors under twelve years of age from entering the hospital all manner of attractions are arranged for their benefit such as swings, little rustic seats and a sandbox. Another corner reveals small figures of dogs and other animals made of wood and realistically painted. Adequate protection is afforded from cars coming up the driveway so that parents may enter the hospital to visit some sick one and leave their children provided for. The hospital does not assume any responsibility for children left to their own devices in this playyard, however.

A Full House

During visiting hours on almost any clear day, it is not uncommon to find every chair and plaything in demand with even an occasional elder attempting to squeeze into a swing or a chair that obviously was not designed for his use. It is significant to note, too, that every toy included in the original equipment remains intact. Not even so much as a single block has been removed.

This introduction is sufficient to indicate that a pencil and notebook will form indispensable items of equipment as the journey progresses. Before jotting down further notes, however, certain facts should be made known regarding this institution which will make the tour of inspection that follows the more intelligible.

St. John's Riverside is a general nonsectarian hospital having today a bed occupancy of 200. It was founded in 1869 by a group of public-spirited men and women of Yonkers who realized the need for such an institution to provide for the sick and disabled of that town and near-by communities. The hospital was incorporated in 1870, and in 1894, having outgrown its quarters, new buildings were erected on the present site. In the same year, the Cochran School of Nursing was organized as an integral part of the hospital and under the same management. The demand for greater facilities kept growing, which resulted in further expansion in 1930, when new buildings including a nurses' home were completed.

Today finds the hospital thoroughly modern in its equipment, six stories in height and with every floor planned as a complete unit. Nurses are supplied by the Cochran School of Nursing, which was

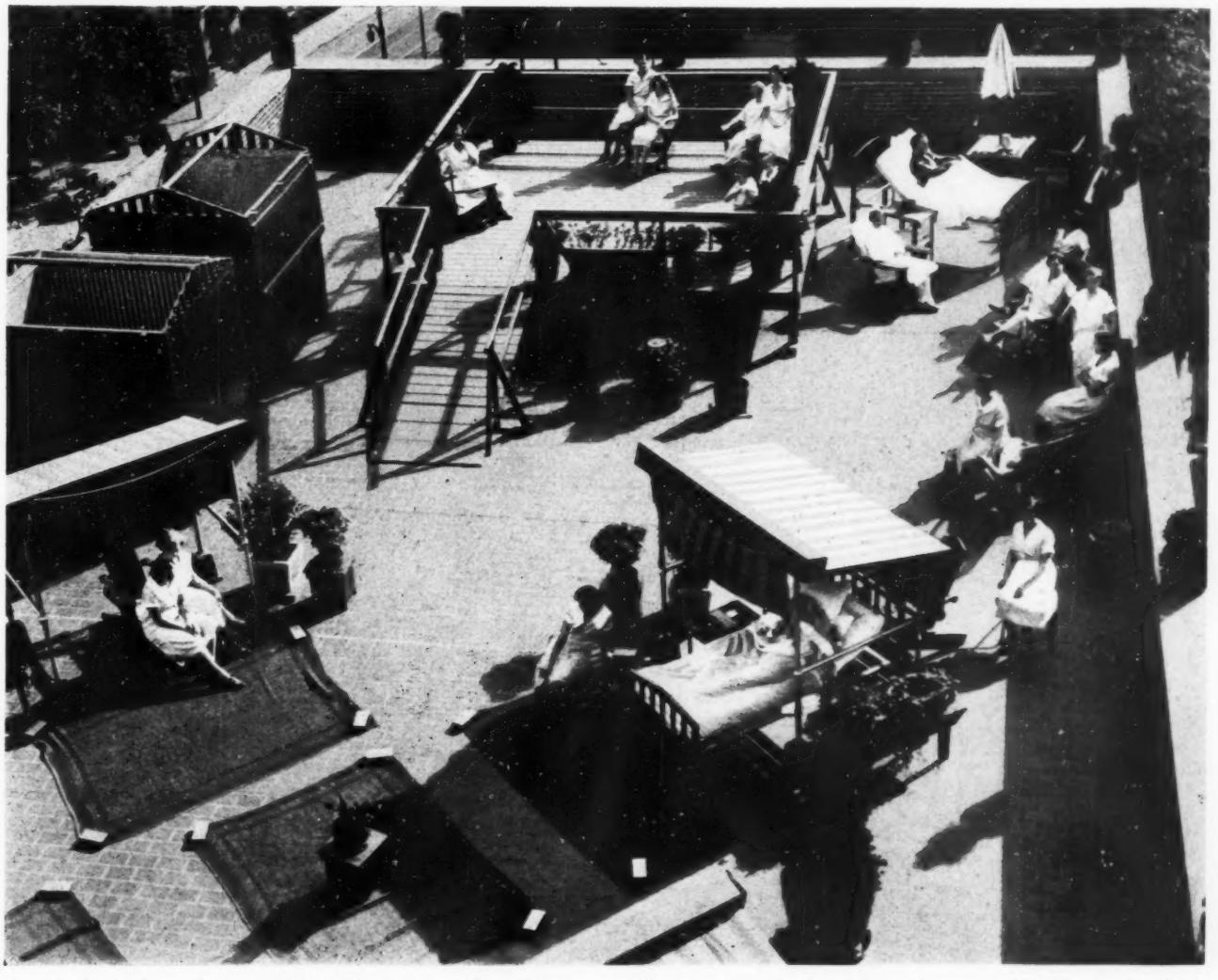
registered with the University of the State of New York in 1907.

The institution boasts an x-ray department comprising a suite of rooms especially fitted for the various examinations such as the radiographic room with stereoscopic apparatus, and special equipment for mastoid pictures, a fluoroscopic room with vertical and horizontal equipment complete, a room designed and equipped for deep x-ray therapy of the most approved type and a room fitted for cystoscopic work.

A complete laboratory contains the newest devices for laboratory tests, and a pharmacy is maintained within the hospital stocked with modern pharmaceutical preparations and drugs. The obstetrical work is housed in a building entirely separate from the hospital proper. Private and semiprivate accommodations are provided and a large ward. The delivery and labor rooms occupy the entire top floor, and there are two nurseries.

A modern physiotherapy department is another feature of the hospital's services including approved electrotherapy equipment and having connected with it a hydrotherapy department with unusual facilities for colonic irrigations. The children's ward is on the main floor and contains an attractively furnished sun and playroom. Directly outside its windows is a playground.

With this general description of the institution in mind, it is now interesting to look around a bit. One point of discrepancy between this Little Journey and any other is that instead of starting out with the superintendent from his office in the administrative suite, we begin in a room located in the basement — a fascinating room, filled with all sorts of lathes, vises, tool racks and other woodworking equipment. It is here that we meet Capt. Harry H. Warfield, who prior to joining St. John's four years ago, was in charge of the Carson C. Peck Memorial Hospital, Brooklyn, N. Y., having taken command there upon his release from the army in 1919. Captain Warfield, outside of office hours, is generally sought and invariably found in one of two places — the carpenter shop or the garden. It is entirely logical, therefore, to start in this laboratory of practical ideas and note the many interest-



A raised platform from which patients may view the surrounding country, tents and sun houses make the roof unique.

ing details evolved there that are constantly being applied successfully to different parts of the hospital.

The properties of the children's playground were conceived and executed in the hospital's workshop. The furniture and sandbox, even the blocks and wooden animals, were fashioned by Captain Warfield personally with the able assistance of an old ship builder, who is the official carpenter of the institution. While becomingly modest about their achievements, they are willing to admit that they not only turn out neat work but work that will stand up under actual service.

A Simple Ventilating Device

We start first, therefore, along the basement corridor. Every door, it will be noted, or at least those leading into the storeroom and the morgue, has been provided with its own ventilating system. Briefly, three round holes bored at the top and at the bottom with brass inserts, permit ingress and egress of air. The same idea has been applied with a minor variation in the dining rooms on the floor above. What closely resembles a porthole inserted in the swinging doors leading from the main hall into the staff dining room and from the staff dining room into the nurses' dining hall permits air to circulate through and thus minimizes any odor of stale food.

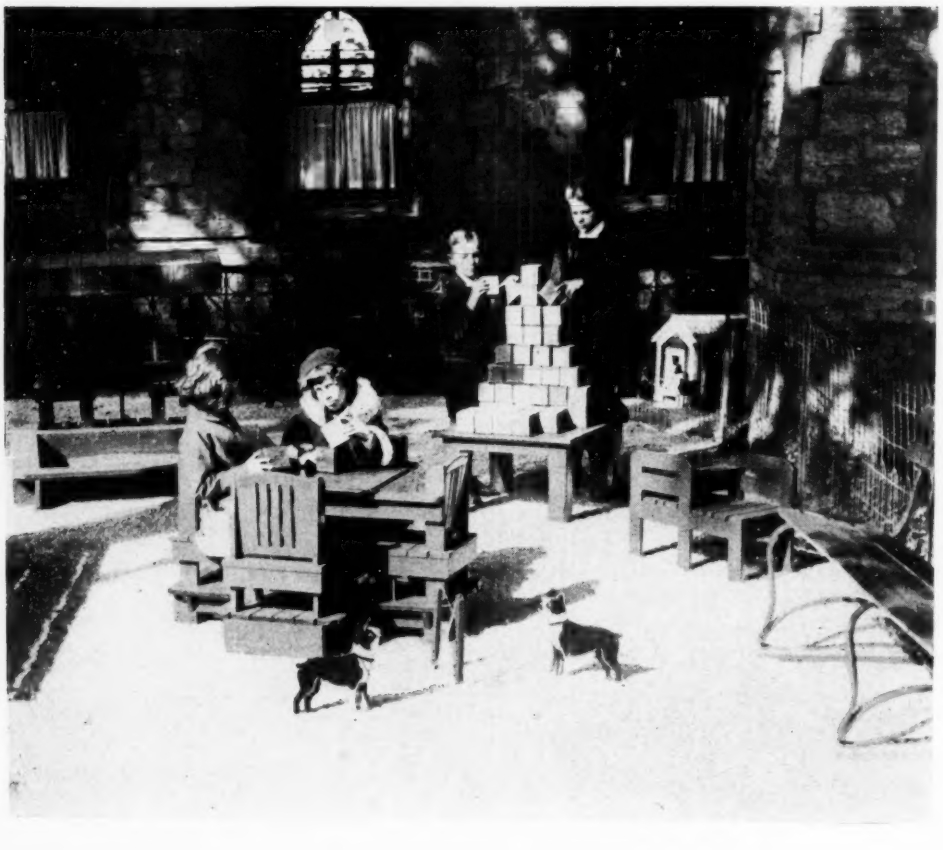
The hospital morgue is not generally a spot of interest. In St. John's Riverside, it assumes a new importance simply because the disagreeable features have been removed and it has been thrown open to public inspection. Everything within is painted white. The sun shining through two windows dissipates all dampness and gloom. The door is left open, inviting attention to an immaculately white necropsy table in the center with the other necessary equipment.

An unusual sight in the laundry is a row of clean white mops. These are ready for distribution to the maids and porters who regularly once a week turn in those they have been using and in exchange receive clean ones. It is required that those returned be in good condition. They are then tied in two different places to prevent tangling and are put through the regular washing process. This entails some expense, to be sure, but experience has proved it to be economical in the long run. Furthermore, there is satisfaction in the knowledge that the mops are always clean.

The Stock Keeper's Notebooks

Next door on a desk in the stockroom is found a series of notebooks, each representing a different department or floor. These constitute a separate record of each unit in the organization, showing entries and requisitions with the O.K. of the supervisor of nurses, the housekeeper or dietitian, as the case may be, also the endorsement of the superintendent. Prices are included, thus providing an accurate record of what goods are removed from the storeroom, the department to which they are charged and the cost.

Several details in the dietary department deserve notice. In a hall-



Child visitors find the play equipment at the front door so fascinating that they eagerly remain outside while parents visit the sick.

way adjoining one of the dining rooms stands a showcase, the gift of one of the directors, in which different food exhibits are staged. Two cans of tomatoes, for example, of precisely the same weight may differ widely in their content, it is shown, one containing far more water and less food matter. The actual cans are on view with their contents plainly exposed.

On the wall is a chart which provides a daily record of food costs. This is posted where those responsible can see it regularly and makes possible a constant check on dietary department expenses.

Protected from cars on the driveway, the playground is a safe place for children.

Cafeteria service is furnished the nurses for breakfast only. The other two meals are served them in their attractive dining hall. This arrangement has solved the problem of getting them to their posts on time in the morning. Rather than wait for their cup of coffee, cereal or whatever they may select from the menu, they can serve themselves and thus save considerable time. This plan has worked to excellent advantage at St. John's Riverside.

Whatever faith may be placed in destinies controlled by guiding stars, there is no question that it all has a direct bearing upon the immaculateness of the kitchen in St. John's. An attitude of respect and even reverence is manifest by the colored chefs in charge toward a small silver star placed in the middle of the ceiling. It stands for things as they should be, and in consequence, as they invariably are. The star guides destinies in that kitchen, if ever a star did.

Two similar stars affixed to the ceiling of the maternity ward have been found to exercise the same mysterious effect upon the patients who gaze at them. A small thing, a star. The visitor even has to glance twice before seeing it, yet mothers lying supine with nothing but blank space to gaze into can weave about it all sorts of comforting and beautiful dreams.

On the way to the roof garden, which by the way, is a story in itself, unusual and exceedingly decorative pedestals are noted, on which stand palms and ferns. Investigation reveals the pedestals to be another hospital product, flaunting a strictly professional air, nevertheless. Captain Warfield conceived the idea of using up broken bits of china by mixing them with cement and pouring the mixture into a mold. When finished, the exterior is polished, which brings out vividly the assorted colors of the china with all the gay abandon of an old-fashioned patchwork quilt.

The entire layout and equipment of the roof garden were conceived and executed in the hospital's carpenter shop. What could be a happier thought than the erection of a raised platform reached by a ramp, thus affording patients an unobstructed view of the entire country, particularly of the Hudson River flowing just below! At each corner provision is made for sun shades. Potted plants, including tall clumps of privet and dwarf pines, introduce a touch of green. The tubs in which they are growing are of individual design, made of concrete and painted green to carry out the prevailing color scheme.

Taborets or small tables have inserted in their tops a hole large enough to hold a large pot of bright petunias or geraniums. Wooden slats forming the sides hide the pot, at the same time affording protection to the roots of the plant from the sun and providing adequate ventilation. Wooden benches are topped with long window boxes also filled with petunias or climbing vines or foliage plants, offering the decided advantage of keeping the plants off the floor and thus enabling the air to circulate about them.

For those patients confined to bed who seek a place of shelter when the sun's rays get too warm, individual lean-tos are provided. These are made of metal frames set in substantial standards over the top of which awning material is stretched. The bed is merely rolled under this covering.

Two sun houses assure absolute protection, while exposing the body to the sun's rays. Built of wood, they are designed so that the roof divides and falls to the sides on hinges. In the event that only partial exposure is desired, slat sides may be swung up and held firmly.

Where the Copper Ash Trays Originated

Even such details as ash trays have not been overlooked. It was necessary to supply a receptacle sufficiently deep to prevent ashes blowing around in a high wind and getting in the patients' eyes, also heavy enough to ensure their staying where put. To the uninitiated, a large copper bowl has been affixed to a wooden stand with exceedingly artistic results. Truth will out. The bowl is merely a float used in the old time steam trap and split in two. Small boxes filled with sand and placed on the floor assure safety for cigarette stubs.

The most recent achievement, which has aroused no small amount of comment, is a piece of furniture combining a table with two chairs, built all in one piece. It is so constructed that two of these fixtures can be put together in such manner as to permit four people to sit and play cards or have tea with the utmost comfort. Luxurious lounge chairs are also provided, luxurious despite their being made of wood, because they happen to furnish just the right support in exactly the right spots.

En route from the roof down to the flower gardens, which it will be recalled, represent Captain Warfield's other hobby, a brief stop is made at a private floor to inspect some of the upholstering work, which is also a function of the carpentering department. The visitor who steps off the elevator enters a little sitting room furnished with a rug, easy chairs, leather taborets and lamps whose shades give a soft, pleasing light. Many a chair that otherwise might have been discarded has been rejuvenated and made ready for additional years of service in the hospital's own shop. These decorative touches are not necessarily expensive. It is surprising what can be done by careful shopping.

It is a long step from the unkept property that surrounded the hospital in former years to the carefully landscaped background that makes it today a place of beauty heralded throughout the entire neighborhood. Spacious flower beds adorn the front entrance and, between the different buildings, attractive bits of green and effective plantings have been devised to eliminate the institutional atmosphere.

It is on the sunny slopes facing the river, however, where imagination has been permitted to run riot, forming a series of gardens, each one of which vies with the next in beauty and originality of treatment. Who would believe that the roof of a boiler room might be transformed into the Rosey Morn Sun Garden? Yet that is precisely what has been achieved. The sharp slope of the ground providing entrance to the boiler room from a lower level afforded adequate space on the roof for laying out a rather formal garden. It was impractical to grow grass under such conditions so the area was put in gravel and beds placed here and there in which certain flowers might be cultivated. Nurses and other members of the staff are invited to spend their leisure moments enjoying the beauties of this garden spot.

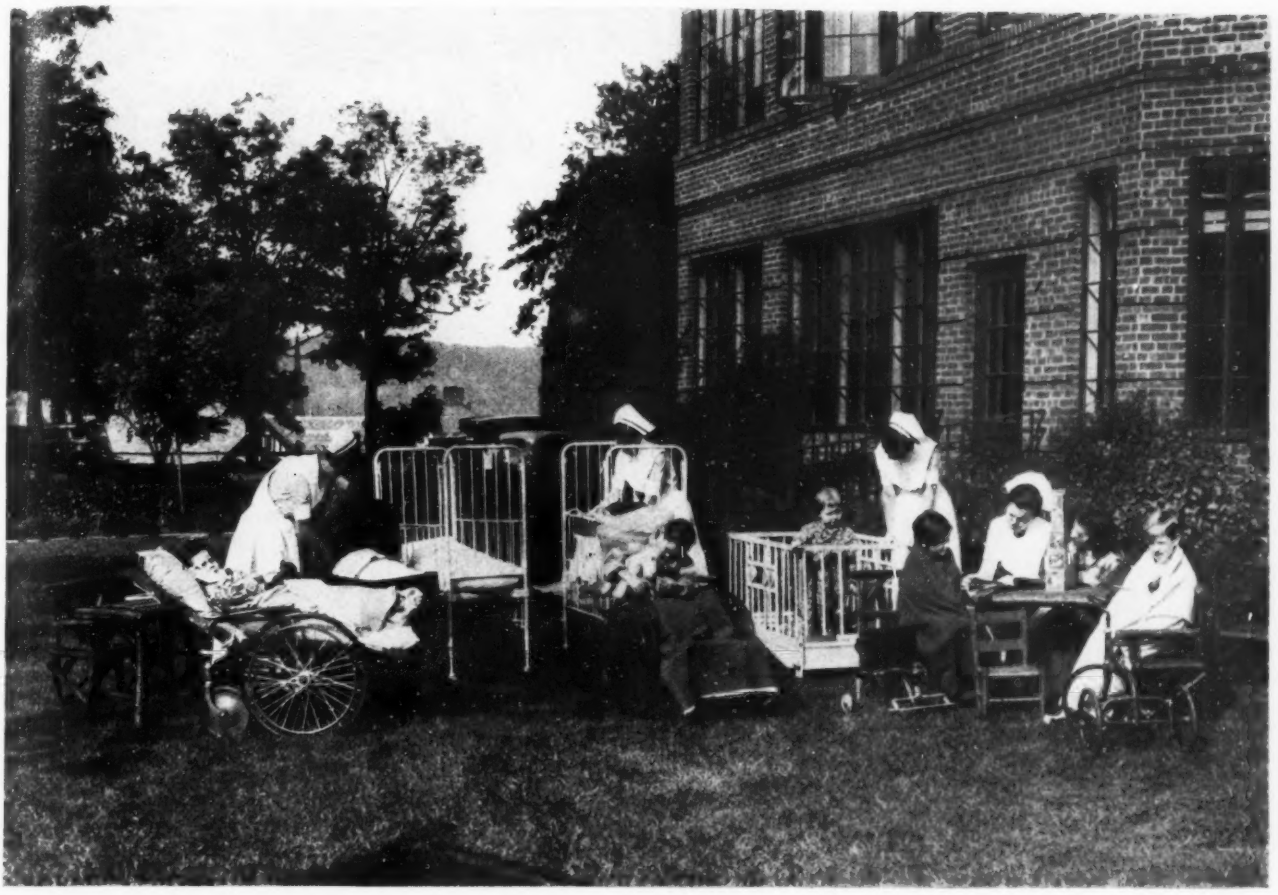
To the rear you enter through a gate to the Green Gate Nurseries. Every real gardener recognizes the necessity for having what in hospital parlance is known as the utility room — some private spot where may be kept a compost heap, the cold frames for nursing young plants and the numerous items of equipment that are conducive to resultful gardening. Green Gate Nurseries boasts even a small greenhouse where seedlings are carefully tended and plants nurtured for adorning the hospital during the winter months.

Coming out of the Rosey Morn Sun Garden, one approaches the Vale of Avoka, on the other side of which are the Sunset Gardens. This forms a slight depression from which steps lead down to the power plant. From a small fountain comes forth a fine spray which blows like mist through the miniature valley, and hereby hangs a tale, told by an English nurse, which is responsible for the Vale of Avoka becoming a reality in the hospital world of St. John's Riverside.

Gardens Are Enjoyed by Employees

There is a certain section, it seems, between England and Scotland where two rivers meet over a rugged ledge of rocks. This forms a continuous mist. Therefore, it became known as the Vale of Avoka, which is interpreted as meeting of the waters.

One of the charms of these gardens is that they are made a part of the hospital life. Sunset Gardens, for example, are a brief bit of greenery and bright planting open to the maids and the porters, who are privileged to use it when they are off duty. Benches are provided where they may read or chat during leisure moments. Progressing further down the slope nearer the main thoroughfare, the visitor enters the Terrace Garden and the Garden of Allah,



Outside the children's ward is a playground for young patients. The Palisades across the Hudson form the background.

both of which are patches of riotous color with perennials and annuals forcing their attention upon every one who enters. Stretches of green grass and shrubs provide a dignified setting.

After inspecting the garden on top of the boiler room, it is only fair to walk down the steps and through the Vale of Avoka to see what lies beneath. At first thought, there may seem to be something incongruous about traversing the Vale of Avoka to inspect a boiler room. On the other hand, who would ever expect to find confronting them at the entrance of a boiler room the following text, "Wipe Well Your Feet, All Ye Who Enter Here."

There is good reason for that sign at the entrance of the boiler room at St. John's. Every bit of machinery, every inch of floor space, is kept freshly painted. It seems almost like sacrilege to bring even the clean dirt of the gardens into that rarified atmosphere. It is surprising how much an occasional can of paint will contribute to the morale of the workers, Captain Warfield has discovered — paint and comfortable working conditions, including locker space and shower baths.

And so back through the Vale of Avoka with a parting glimpse into the Rosey Morn Sun Garden, where two young nurses are sitting on a stone bench. Here it becomes necessary to inscribe one last memorandum in the now overflowing notebook — the bench is made of concrete, another product of that laboratory of practical ideas to which may be attributed the reputation of St. John's Riverside Hospital as an institution which believes that, when all is said and done, it is the little things that count.

A Bit of Hospital History

Twenty years ago this month:

Dr. D. S. Fairchild of Clinton, Iowa, a prominent surgeon and a vice president of the American Medical Association, charged that pupil nurses were a hazard to patients. Because of this statement, he was barred from the hospitals of Clinton.

Editor John A. Hornsby interviewed patients in fourteen tuberculosis hospitals, and found that while they were well fed, well nursed and well looked after medically, all confessed to great loneliness. In an editorial it was urged that occupations, diversions and entertainment be provided persons in sanatoriums to keep them happy and contented.

Municipal hospitals of Boston announced salary increases of from 20 to 30 per cent for all employees. Under the new schedule, the superintendent of nurses received $1,500 a year, graduate floor nurses $600 a year, the laundry supervisors $1,150 a year and scrub women $30 a month.

King's Daughters' Hospital, Madison, Ind., was erected at a cost of $30,000.

What Others Are Doing

Paying for Hospital Care With Fruits and Vegetables

One small East Texas community in Henderson County, has no hospital. Yet every indigent citizen in need of hospital care gets it. In the spring and summer when fruits and vegetables are plentiful, this community cans and packs its surplus crop. By a cooperative scheme the food is sent to Baylor University Hospital, Dallas. The hospital buys it, giving credit against the time when some indigent sick person from this community needs hospital care.

This plan proved so successful in the one small community that the entire county adopted it and now it is managed by the Red Cross. This organization sends the hospital more than ten thousand dollars worth of farm produce, mostly canned goods, which is taken up in hospital service. The arrangement has been most satisfactory both to the community and to the institution, according to Bryce L. Twitty, superintendent of the hospital.

The quality of canned goods is controlled by the supervision of the county home demonstration agent. The hospital keeps account of the patients by ear-marking the ledger card, and charges them regular prices for service rendered to them, giving them ward accommodations.

Sweet potatoes, Irish potatoes, onions, canned beef and pork, chickens, turkeys, dried fruits of all kinds, fresh fruits, fresh tomatoes, canned peas, canned beans, canned peaches, canned pears, honey, all kinds of preserves, fresh vegetables of all kinds and watermelons are supplied. The quality of merchandise has always been of the highest type, according to Mr. Twitty, because each housewife tries to outdo the other in sending in beautiful canned goods.

Booklet for Convalescent Patients

"A Journey of Discovery While Lying Abed" is the title of an illustrated pamphlet issued by the University Hospitals of Cleveland, of which Dr. R. H. Bishop is director. When a private or semiprivate patient begins to convalesce, he is given a copy of the pamphlet which opens with the following paragraph:

"We hope you feel well enough today to embark on a little journey of discovery. We want you to know of the scope and purpose of the University Hospitals. While you rest comfortably in bed, let us take you, through the pages of this little booklet, on a personal tour of the many institutions and

Decoration on Babies' and Children's Hospital, Cleveland, used as an illustration in a book for convalescents.

buildings that compose what is known as the Medical Center. We know you will find the trip interesting, for many of the departments you will visit and the work that is carried on in them, day and night, directly concern your return to good health."

The pages following carry a brief outline of the physical aspects of the various institutions that compose the University Hospitals group. It is believed that the publication will be valuable in public relations work.

School Helps With Sewing

A vocational school maintained by the Seattle Public Schools system has been of great value to the King County Hospital System of that city in the making of hospital linens of nonstandard sizes. The sewing pupils thus augment the work of the hospital sewing room. The hospital furnishes the material and the school supplies the labor at a charge only sufficient to cover the cost of needles, thread and other small supplies. The hospital profits by having a source of unpaid labor and the school by having material on which to work. Since the sewing classes in the vocational school attempt to train girls for factory sewing, they must have orders of factory size.

Free Post Cards for Patients

Baylor University Hospital, Dallas, Tex., supplies free post cards for guests in the institution to mail out to their friends and relatives.

An attractive colored picture of the hospital is shown on one side of the card, while on the reverse side is the following brief description of the institution: "400-bed general hospital, modern equipment and conveniences. Highest rating and approval by such bodies as American Medical Association, American College of Surgeons, American Hospital Association."

Hospital authorities feel that the advertising more than pays the cost.

Graduate Nurses Cost More

William P. Butler, manager, San Jose Hospital, San Jose, Calif., reports that that institution changed from student to graduate nursing service in August, 1933 with the result that nursing cost per patient day has increased 42 per cent. Better service is obtained with graduates, however, and the ratio of nurses to patients has declined.

Assuming that five students may be replaced with three graduates—San Jose Hospital furnishes complete keep for both types of service—the figures are about as follows:

3 graduates @ $77.75		$233.25
5 students @ $5.00	$25.00	
Laundry	25.00	
Training	50.00	
Care	18.00	
Miscellaneous	47.00	
		$165.00

San Jose Hospital is an institution of 110 beds.

Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals

FERA Projects That May Be Useful in Your Town

By ALDEN B. MILLS
Managing Editor, The MODERN HOSPITAL

IT IS already obvious that this coming winter will see a continuation of relief on a large scale, financed in part by federal funds. Among the millions of persons receiving aid will be many who have skills of one kind or another.

The FERA wishes to develop projects for the employment of these persons in socially desirable work that will not only benefit the public but will keep them mentally active. If these projects can create new types of work to take the place of old jobs that have disappeared, so much the better.

Knowing that there were many opportunities in the field of health work, The MODERN HOSPITAL last month requested suggestions from hospital people for socially desirable projects that could be set up for the employment of persons receiving relief. A flood of valuable suggestions has come into the office and has been forwarded to Washington. They should be taken up with local relief officials.

In addition to the suggestions for new projects, a number of statements have been received describing projects carried on last year or in earlier years. These are particularly valuable.

Alameda County Projects

Several of the most interesting projects were carried on in Alameda County, California. In order to reduce expenses and meet the demand for service the county hospitals there have been discharging patients at the earliest possible time. Some of these patients, particularly the home makers, had difficulty in caring for their families. Under the sponsorship of the county hospitals, therefore, the relief administration organized a group of women, whom it is aiding, to go into such homes and do the necessary household work such as cooking, cleaning, dressing children and getting them off to school. These "visiting housekeepers" are under the direction of the Visiting Nurse Association but are not expected to perform any technical nursing services. The plan has worked out very well, according to Dr. B. W. Black, medical director, Alameda County Institutions, "and it has permitted the county to give adequate hospital care with a much shorter stay in the institution."

In the same county nurses on relief have been employed to visit the homes of poor families and survey the physical surroundings, the health of the family, the teeth of the children and similar matters. As a result a large amount of corrective work has been done for these families as well as treatment for acute conditions which, for one reason or another, was being neglected.

The Alameda County Hospitals have also had a careful study of clinical records made by persons on relief directed by the visiting medical staff.

Some New York Successes

At the other side of the continent in Poughkeepsie, N. Y., twenty-six visiting nurses, on relief funds, are employed in the county, about a dozen nursery schools are being manned by relief workers under the direction of the Vassar College Euthenics Department, and women have been assembled to sew for the needy and to prepare infant layettes, sterile obstetrical packages for home deliveries and hospital dressings. For several weeks teachers and other educated women were used as visiting nutritionists but the project was discontinued because of dissatisfaction with the management and personnel.

Montefiore Hospital, New York City, has had experience with the use of relief workers for almost three years, having employed persons who were receiving help from the Jewish Social Service Association. Projects have been designed to be of help to the worker as well as to the hospital and many of the people have learned trades. Much of the work has been on the hospital's physical plant such as improvements to the grounds, waterproofing of foundation walls and repairing of the dormitory roof. Other projects have been carried out in the engineering department, laundry, kitchen, plumbing and carpenter shops, research laboratories, occupational therapy department, operating room and pharmacy. One man was employed to rebind all the worn books in the patients' library. He became so adept in the work that he could undoubtedly be employed anywhere that such service was needed. Another worker was ward librarian.

The director of the hospital declared that "the project is still going strong and we have had as many as eighty workers at one time scattered in the various departments where they spend varying periods of time till they can secure employment in industry as a result of their training. I need hardly add that the experiment carried on so successfully here was done without injury to our pay roll or to the morale of our working staff."

The new projects suggested by readers of The MODERN HOSPITAL fall into several quite different fields. Some have to do with improving buildings and grounds, others with various types of educational projects. The largest group are for the rendering of actual medical services of one kind or another.

Some of the correspondents make general suggestions or issue warnings. The general suggestions are twofold: first, that in most large cities it would be wiser to have a group of hospitals work out projects than to have them put forth by single institutions, and, second, that requests should be confined to measures that afford public benefit rather than measures that are conceived primarily for the benefit of the hospital itself. A few writers warned that in small towns, particularly, it would be difficult to find enough capable persons on the relief rolls to carry on any very worth while projects, while others stated that they thought the amount of red tape that must be complied with and the probable temporary nature of the plans would be disadvantageous. Most of the letters, however, were decidedly constructive in approach.

Proposals in Medical Field

In the field of medical service the following proposals were made:

1. Use properly trained mental hygienists to help persons on relief and others in straightened circumstances to meet the strain of present conditions and to avoid mental disturbances.

2. Use persons who have manual skills as occupational therapists in mental hospitals and sanatoriums and in general hospitals that have many accident cases or other patients with long convalescence.

3. Use dentists and dental hygienists to give dental care to unemployed persons and those with very low earnings.

4. Assign public health nurses particularly to rural and small town hospitals to assist patients after discharge. If the nurses available on relief rolls are not competent to do public health nursing let them substitute for nurses on the staff.

5. Use medical social workers in the same way.

6. Use unemployed nurses to develop home obstetrical services in the smaller communities where such services are not now available to mothers.

7. Expand present clinic services through the employment of more physicians, nurses, social workers, clerks and dentists. This could be done in many instances without any additional investment for plant or equipment and would help to relieve overcrowded conditions in many clinics.

8. Remodel existing buildings to become convalescent homes. These are greatly needed in most communities and could be had at small cost.

9. Set up a project for the careful canvass of the population to discover tuberculosis and for the thorough treatment of the disease at the earliest possible time so that the present depression will not result in a substantial increase in the amount of tuberculosis.

10. Employ and train obstetrical nurses who can give good maternity care to the Mexican population in Southern Colorado.

11. One superintendent states that he would like to open an out-patient department and would be able to raise enough funds to do so if labor could be supplied for the construction.

Other Projects of Traditional Kind

Closely allied to this group of suggestions are some proposals for supplementary or additional hospital service of the traditional kinds:

1. Provide internships in small hospitals for young graduate dietitians who are unable to find employment. If placed temporarily by FERA they would probably prove their worth and find permanent employment with advantages to the hospital, the doctor, the community and, of course, the dietitian.

2. Many superintendents suggest that under present conditions they are unable to provide adequate floor nursing service to their ward patients and others unable to purchase special nursing care. With extensive unemployment among nurses, a way could be found to remedy this.

3. One superintendent reports that he wishes to change his record system to the new Standard Classified Nomenclature but is unable to do so unless he can have some clerical help in changing the indexes.

4. One prominent superintendent stresses the inadequacy of nursing service in tuberculosis and municipal hospitals and urges that additional nurses be provided from the relief rolls.

5. The promotion of group hospitalization plans where these have been set up under proper nonprofit auspices would be a distinctly desirable project, several superintendents point out.

6. One hospital requests that nurses be assigned to it to visit periodically all families on the relief rolls and refer those needing care to cooperating

private physicians or to clinics. The hospital offers to supervise the work of such nurses through its clinic staff.

7. The same hospital offers to organize and direct a campaign for diphtheria immunization, if nurses can be provided from relief rolls to make house-to-house visits. Proper safeguards would be set up to protect the interests of private physicians.

8. A New Jersey superintendent is aroused by the increase in the crime rate and the mental illness rate among adolescents. She suggests that a psychiatric social worker be assigned to work with problem school children under eleven years of age.

9. A superintendent proposes that 200 nurses be enrolled in a campaign to wipe out venereal disease in Pittsburgh.

10. Another suggests that the present offers an unusual opportunity to strike a decisive blow against certain preventable diseases. He proposes that physicians and nurses on relief rolls be used to vaccinate against typhoid and smallpox and immunize against diphtheria all persons on relief, all government employees and all school children.

Research Projects Suggested

Research projects of various kinds attract the interest of several contributors. In general the FERA believes that too many of the projects that have been proposed in the past have been of a research character, but in spite of that they might be willing to support well conceived research projects if the need for the studies were clearly demonstrated. Those proposed are:

1. A careful analytical study of the costs of various hospital departments.

2. An analysis of statistics on group hospitalization.

3. Clerical and secretarial assistance in the work of hospital councils. Many communities are probably ready to form councils but lack funds.

4. Clerical aid for the operation of social service exchanges.

5. Clerical help in the study of clinical records in hospitals that have kept good records.

6. Careful studies of the end results of hospital treatment, including a follow-up of patients after discharge.

7. Medical and social service studies of what happens to persons when ill if on relief rolls compared to what happens to other persons of about the same background not on relief rolls.

8. A thorough study of the possibilities of integrating the community's preventive health work.

9. A full study of automobile accident cases, including the cost of their medical treatment and how it is paid.

Of the educational projects proposed some relate directly to health work and others only indirectly:

1. Use intelligent women to teach home economics to relief families so that they may be helped to purchase correctly and to provide proper diets.

2. Employ doctors, nurses and others in the medical field to instruct the public, particularly persons with small or no incomes, in sanitation and hygiene.

3. Teach expectant mothers about child raising and develop child guidance clinics for the use of parents.

4. Conduct adult vocational education for persons requiring long hospitalization, especially tuberculous and chronic orthopedic cases. Such a project, however, needs continuity in the teaching force for best results.

5. Accept apprentices in hospitals with orthopedic departments to receive training as bracemakers. It is reported that there is a shortage of qualified bracemakers in this country.

6. Use physicians and nurses to carry on a campaign of public education regarding the mentally ill and make studies looking toward the revision of the many antiquated laws on this subject.

7. Provide trained recreation directors for the general population in cities and towns and for the employees of large isolated hospitals where most of the employees live on the hospital grounds.

Improvement of Grounds and Buildings

While there is some difference of opinion as to the wisdom of using persons on relief for the improvement of the hospital buildings and grounds several persons suggested projects of this kind. They included:

1. Repairs and painting that cannot otherwise be done until hospital finances improve substantially.

2. Landscape gardening and tree surgery.

3. Private police to control automobile parking, handle uncooperative visitors, take charge of employees who return intoxicated and perform similar duties.

4. One superintendent of a large hospital that is rather isolated proposes that the government use relief labor to build garages on the hospital grounds for the use of employees. The cost of materials could be repaid from small fees.

5. Install sprinklers and other fire protection devices so as to safeguard the lives of patients and employees.

Persons who are interested in such projects should get in touch with their local relief officials as soon as possible and present to them sound plans which have been carefully thought through.

A Construction Camp Hospital

By DANIEL M. BROWN, R.N.
Chief Nurse, Berdoo Hospital, Camp Berdoo, Calif.

WHEN Berdoo Hospital, which is a unit of the Metropolitan Water District of Southern California, was opened more than a year ago, it was decided to staff it, so far as nursing service is concerned, entirely with male nurses. This decision was reached because of the isolated location of the camps, the fact that men constitute the entire personnel of the camps, and the ability of the male nurse to care for the emergency patient satisfactorily.

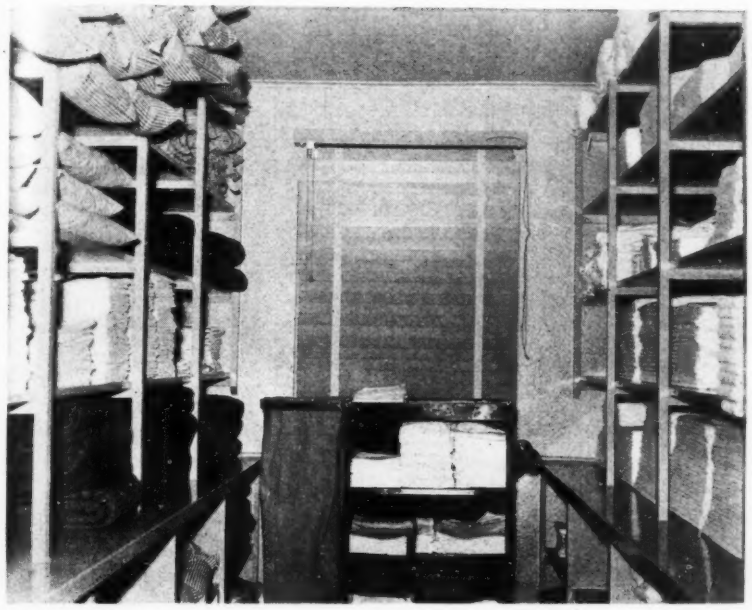
The Metropolitan Water District of Southern California is a large corporation engaged in building an aqueduct, 241 miles long, that will bring water from the Colorado River to thirteen cities, including Los Angeles. An average of 1,500 men have been employed in the Coachella Division served by this hospital and this number is increasing constantly as the work progresses.

Berdoo Hospital is air conditioned throughout, owing to the extreme temperatures of the desert; the total cost was $6,000. The system is also used to heat the hospital in the winter by the use of steam pipes. In addition to this hospital, there are eight branch emergency units of four beds, each manned by first aid nurses.

In the hospital proper there are twelve nurses, a chief nurse and the laboratory technician, who is also a registered nurse. Nurses are from the U. S. Navy, the Los Angeles General and the Glendale Sanatorium hospitals, these institutions having schools of nursing admitting men. Only nurses who are registered in California are employed, and preference is given to those who have had experience in surgery and emergency nursing.

No orderlies or nursing aides are employed at Berdoo. This has worked out satisfactorily in that the patient has intelligent, thoughtful care for every nursing procedure and does not have to be referred from one group to another, the male nurse doing all that is necessary for his comfort.

Duty is restricted to eight hours and this policy is said to have more than paid for itself by in-



creased returns in efficiency. Group nursing is done whenever possible among those patients requiring special nursing.

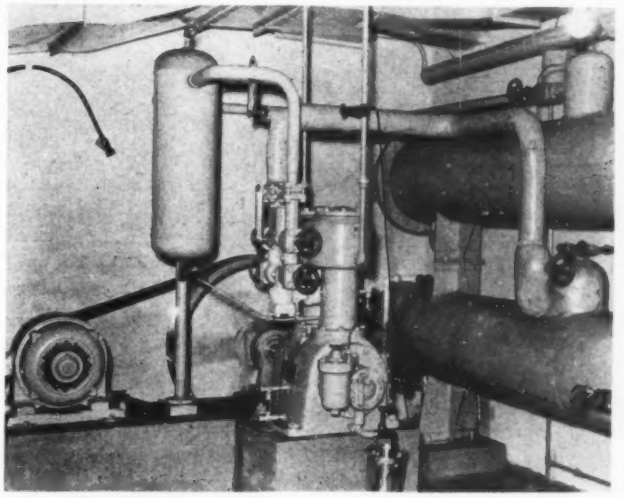
Living quarters are plain but comfortable and are of the dormitory type.

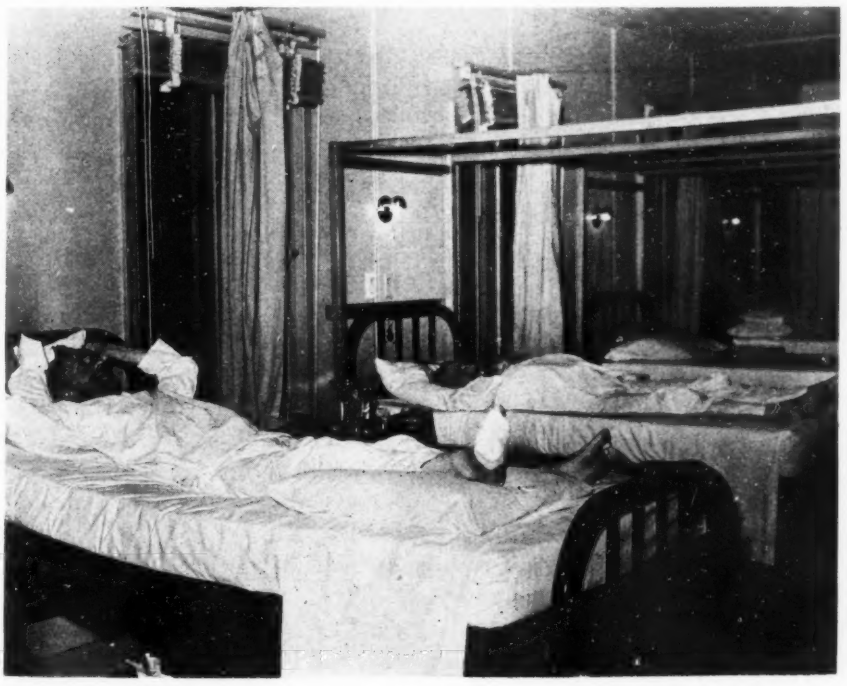
Nurses man the ambulance whenever it is dispatched and have been instrumental in preventing further injury to patients and in increasing the efficiency of the first aid rendered at the scene of the accident.

From the experience at this hospital, an institution of 37 beds, it would seem that nursing with an exclusively male registered nurse staff is both practical and desirable under certain conditions. The patients have been well satisfied with the type of service and have commented on the gentleness and understanding the nurses have exhibited.

NOT to be judged by external appearances—for the exterior is of temporary construction—this camp hospital in the desert region has equipment that would do credit to the most up-to-date urban institution. The building and its medical and nursing staff (all men) are shown on the opposite page.

On this page may be seen views of the linen room, the ice compressor for the air conditioning plant and the orthopedic ward. Air conditioning machinery for the hospital cost $6,000. The system heats the hospital in winter by means of steam pipes. Propane-butane gas is used as fuel. All the frames in the orthopedic ward were made by the house carpenter for $12.





The cooperative plan used by the Metropolitan Water District in treating its employees will be briefly outlined.

Each employee pays five cents a day for hospital and medical care, this amount being deducted from his pay check. This entitles him when he is ill to hospital care, medical treatment, special nurses if needed, and all x-ray and laboratory examinations. According to the contract between employee and employer he is entitled to these various services for a period of six months or to the extent of $1,800, whichever limit is

reached first. The contract does not provide for the treatment of mental, venereal, and chronic diseases or for alcoholic disturbances. So far, the common communicable disease cases have been treated under the plan.

To date the fees received from employees have taken care of their illness without a deficit. All the men must pass a physical examination before they are employed and stress is put on prevention of illness.

The men are always encouraged to come to the hospital and first aid camps for treatment at any time of the day or night. The district does not provide dental care nor does it fit glasses. Mouth x-rays are taken in many cases when there is a focus of infection suspected, and this frequently results in a change of status of the case from compensation to medical.

Special nurses, oxygen tents and serums are provided whenever needed, and no effort is made to economize at the patient's expense.

When an employee is no longer a hospital patient, but may be cared for adequately in the outpatient department, he is assigned a room in the camp dormitory and his board and room are paid for by the fund, so there is no hesitancy on a patient's part in leaving the hospital. This camp hospital is able to accommodate acute cases only.

An Organization to Promote Good Obstetrics

By A. J. SKEEL, M.D.
Cleveland

THE Hospital Obstetric Society of Ohio is a society of physicians with distinctive purposes and expectations. Its plan of organization and its proposed activities are, so far as I know, entirely new in the medical world.

The society proposes to carry out on a magnified scale the methods and purposes of the staff conference — review of cases, formation of statistics, study of results and discussion of methods to improve those results, whether clinical or organizational in their nature. The work of the society is distinctively practical. It will deal with doctors and their effectiveness in applying scientific knowledge, with men and their methods, rather than with theories of disease.

Article two of the society's newly adopted constitution states that "it shall be the purpose of this society to develop better methods for hospitalization and care of the obstetrical patient and the newborn child. To this end it is our purpose to study all the conditions which affect the welfare of patients who enter hospitals for obstetrical care, and to introduce and standardize methods for the improvement of the care of such patients."

The proposed program for the Hospital Obstetric Society of Ohio contains the following points:

1. Adoption of a continuous audit system of hospital obstetric mortalities and morbidities.
2. Development of a code of rules and regulations to govern (a) conditions of housing and equipment and (b) administrative policies, whenever such policies are directly related to the patient's welfare.
3. Adoption of a uniform system of staff organization and control.
4. Enactment of legislation which will compel conformity with the principles of such a code, by institutions or individuals who from selfish motives or indifference are unwilling to comply.
5. Systematic development of hospital facilities for maternity cases throughout the state, with distribution designed to give both metropolitan and rural population suitable service.
6. Development of a consistent program for teaching women the importance of prenatal care.
7. Provision for as nearly complete hospitalization of maternity cases as the facilities and conditions of individual communities will permit.

The subject of better staff organization is, in my judgment, the portion of our program most difficult of attainment and the most vital.

To accomplish adequate organization, the hospital must (1) select its own staff with extreme care, choosing men of unusual skill and with the highest ideals; (2) place on its courtesy staff only such men as will use its facilities with a view to the patient's welfare, and (3) establish standards, rules and limitation on practice within its walls necessary to give the patient the greatest safety.

In smaller institutions a highly organized staff may be impossible. However, the smallest hospital accepting obstetric patients can appoint a consulting obstetrician who can advise on policies, techniques and housing arrangements. Such flagrant violation of the essential principles of safe obstetric service as the combined operating room and delivery suite and the miscellaneous distribution of nursing service among both surgical and maternity cases would thus be obviated.

A New Set of Standards for Textile Buying

By GRACE G. DENNY and MARY W. NORTHROP

Associate Professor of Home Economics, University of Washington, and Chief Dietitian and Housekeeper, King County Hospital System, Seattle, Wash., Respectively

Part II

IN THE choice of fabrics for the use of any institution, part of the problems presented can be decided on the basis of laboratory tests, and part must be decided by the administration of the particular institution involved. The type of bedspread to be used, for example, will depend on the general furnishing scheme and on preference, and relative tensile strengths will influence the decision very little. Some institutions will use cotton damask for table cloths and some cotton suiting, and the selection will be made after weighing appearance against cost. The choice of color in the hospital is a matter of personal taste and is of no serious economic importance. All such discussions are omitted from this report, which aims to present only impersonal and objective judgment.

On the basis of federal specifications and of the preliminary study made by Miss Olcott, specifications have been prepared for the King County Hospital System for the leading items of its textile supplies. They are presented with the realization that the conditions prevailing in one institution are never duplicated in another. While these textile standards will not exactly meet the requirements of any other hospital, it is hoped that they may prove suggestive and helpful.

Sheets

Grade: The sheets shall be of a grade commercially known as firsts.

Material: 1. The sheets shall be made of a sheeting that shall be of cotton, bleached or unbleached as specified, thoroughly cleaned and free from waste, evenly woven, and free from an excessive number of imperfections in manufacture.

2. The weight of the material in these sheets shall be not less than 4.6 ounces per square yard.

3. The thread count shall be 74 in the warp and 66 in the filling for bleached sheets, and 68 in the warp and 72 in the filling for unbleached material.

4. The breaking strength, by the grab method, shall be 70 pounds both for the warp and filling.

Hems: Hems shall be of a width shown in the schedule following. Hems shall be neatly stitched with number 50/3 white cotton thread with not less than 14 stitches to the inch. No ragged edges shall be visible. Corners shall be evenly and securely finished and stitched across the selvage end.

Size: The sheets shall be furnished in the widths and lengths (torn) shown in the schedule below, allowing a tolerance of plus or minus one-half inch.

TABLE V—SPECIFICATIONS FOR BLEACHED AND UNBLEACHED BED SHEETS

Type	*Size (inches)*	*Material*	*Hems*	*Use*	*Mattress Size (New) (inches)*
A	108x72	Bleached	2″	Patients' beds, Hospital 1	75x36x7½
B	108x63	"	2″	Personnel beds, Patients' beds, Hospital 2	75x39x5 75x36x4
C	99x54	"	2″	Youths' beds	70x27x4
D	81x45	"	2″	Cribs	51x26x4
E	36x45	"	1″	Bassinets	27½x13x2
*F	81x54	Unbleached	1″	Draw sheets, Adult, Hospital 1	75x36x7½
*G	75x54	"	1″	Draw sheets, Adult, Hospital 2	75x36x4
*H	63x45	"	1″	Crib draw sheets	51x26x4

*The use of unbleached draw sheets has been customary in Hospitals F, G and H. In view of the recent findings as to the relative shrinkage, cost and tensile strength of bleached and unbleached sheeting, it is quite possible that there would be an advantage in changing to the use of bleached sheeting for this purpose. Bleached sheeting is smoother than unbleached, and has a better appearance.

If this change were made, the difference in amounts of shrinkage to be expected would change the specifications to read as follows:

Type	Size
F	81x45
G	72x45
H	63x36

The only apparent disadvantage is difficulty in sorting. Difference in size and weight would make the draw sheets easy to distinguish from the adult bed sheets. The fact that the adult draw sheets are identical in size with the crib sheets might make it possible to use the same sheet for both purposes, thus eliminating one item from the inventory, and avoiding the necessity for sorting. In this case, the width of hem would be a matter for discussion.

Discussion: Federal Specification DDD-S-281 (1931) has been used as a basis for the specifications for bleached sheets, and Federal Specification CCC-S-291 (1931) has been used as a basis for the specifications for unbleached sheets.

Thread count is ordinarily quoted for material in the gray. In the bleaching and calendering proc-

ess the cloth is stretched in length and the filling threads consequently become further apart. The cloth also becomes narrower, bringing the warp threads closer together.

The count given for the bleached sheeting (74 by 66 inches) corresponds to the count given for unbleached sheeting (68 by 72 inches) after finishing. It is given for the purpose of checking the delivered sheet against the specifications.

Current practice favors the purchase of sheets with hems of equal width at both ends to save motion in making the bed and to equalize wear.

The size of the sheet is customarily expressed as torn length and actual width. While some manufacturers have suggested that they may soon start labeling sheets with their finished size, such is not now the practice. In estimating the required size, allowance must be made for shrinkage and hems, and it must be borne in mind that current commercial laundry practice tends to stretch bleached sheets in width. The size of the sheet is determined primarily by the size of the mattress. The length must allow for hems, shrinkage, covering the mattress and tuck-under. The width must allow for covering the mattress and for tuck-under, and in the case of unbleached sheets also for some shrinkage. Convenient formulas for calculating the required sizes of sheets are as follows:

Bleached Bed Sheets

Length
- Length of mattress
- 2 x depth of mattress
- 2 x required hem
- ½" tuck-under for hems
- 15% of length of mattress for tuck-under
- Subtotal
- Plus 8% of above for shrinkage
- Total length of sheet (torn)

Width
- Width of mattress
- 2 x depth of mattress
- 50% of width of mattress for tuck-under
- Subtotal
- Less 4% for stretch in laundering
- Total width of sheet

A typical calculation by the foregoing formula would be as follows, for a mattress measuring 75 by 36 by 6 inches.

Length			
Length of mattress	75"		
2 x depth of mattress	12		
2 x hems	4		
Tuck-under for hems	½		
15% for tuck-under	11	102½"	
8% for shrinkage		8	
			110½"
Width			
Width of mattress	36"		
2 x depth of mattress	12		
50% of width of mattress for tuck-under	18		
		66 "	
Less 4% stretch		2½	
			63½"

The sheet thus called for would measure 110½ by 63½ inches. Since it is impractical to specify nonstandard sizes, necessitating special manufacture, the nearest standard size (108 by 63 inches) would be recommended for purchase.

For the single bed used for personnel, the same method of computation can be used. A tuck-under of 35 per cent of the mattress width is satisfactory.

Draw Sheets: Similar formulas may be used in the calculation of the size for draw sheets. If the draw sheet is made of unbleached sheeting an allowance must be made for shrinkage in the width, but a smaller percentage of shrinkage will probably be found in the length than in bleached sheets because the finishing process stretches the cloth. The draw sheet should be several inches wider than the rubber sheet. It should cover about two-thirds of the length of the mattress. It must be long enough to give a tuck-under at least equal to one-third the width of the mattress on each side. The formulas for the calculation of the size of a draw sheet would therefore be as follows:

Unbleached Draw Sheets

Length
- Mattress width
- 2 x mattress depth
- 2 x hems
- ½" for tuck-under for hems
- ⅔ of mattress width for tuck-under
- Plus 5% of above for shrinkage

Width
- ⅔ of mattress length
- Plus 6% for shrinkage

Bleached Draw Sheets

Length
- Mattress width
- 2 x mattress depth
- 2 x hems
- ½" for tuck-under for hems
- Plus 8% for shrinkage

Width
- ⅔ of mattress length
- Less 4% for stretch

Calculated for a mattress measuring 75 by 36 by 6 inches, the size of the draw sheet would be as follows:

	Calculated Size (inches)	*Nearest Standard Size (inches)*
Bleached	80½x48	81x45
Unbleached	78 x53	81x54

The formula has not been used in calculating the size called for in the specifications for bassinet sheets because the nurses in this hospital prefer to double the sheet, using the upper sheet as both sheet and spread, with the blanket between. The sheet is therefore used the wrong way of the bed and is made of 45-inch material with the hems on the long sides. This is a nonstandard sheet.

Pillowcases

Grade: The pillowcases shall be of a grade commercially known as firsts.

Material: The material shall be the same as that

required in the specifications for bleached sheets.

General Requirements: 1. Size: The torn length shall be 36 inches, with a finished length of 32½ inches. The material shall be of one piece 45 inches wide, and finished not less than 44 inches. A plus or minus tolerance of one-half inch will be allowed on each of these dimensions.

2. Seams and Hems: The pillowcases shall have a 3-inch hem at the open end. The hem shall be straight and of uniform width and shall show no raw edges. The end seam, the side seam and the turn-under on the hem shall not be less than one-fourth inch. Hem and seams are to be securely stitched with an overlocking stitch, using 50/3 white cotton thread with not less than fourteen stitches per inch.

Discussion: The specifications for pillowcases are based on Federal Specification DDD-P-351.

The specification as to width of material is given to prevent cutting the pillowcase the wrong way of the goods, as was done for one hospital purchase. Cases so made will shrink narrow in the first washing. Allowance has been made for shrinkage only on the 36-inch dimension of the case.

The pillow for which these pillowcases were planned measures 25 by 19 inches. The finished pillowcase will measure 32½ by 22 inches. This allows sufficient length to hold the case in place. A 2-inch hem might have been specified if the additional inch in finished length had been considered of value. The allowance of 3 inches on the width makes for convenience in dressing the pillow and prolongs the life of the case by avoiding strain. The next smaller standard pillowcase is 42 inches in circumference. This case would be 20½ inches in width when finished, which is not enough allowance over the size of this pillow. For use on a smaller pillow, this size of case might well be specified.

Many institutions purchase pillowcases made of tubing rather than of flat sheeting. It is slightly more costly, but has the advantage that if the case begins to wear on the edge the end seam can be cut off and the edges changed.

Wool Blankets

Grade: The blankets shall be of the grade commercially known as firsts.

Material: The blankets shall be of 80 per cent virgin wool and shall be free from shoddy, flocks, waste, noils, reworked wools other than new bleached clips, vegetable matter and other impurities. The permitted 20 per cent cotton shall be entirely in the warp.

Workmanship: The blankets shall be free from imperfections of manufacture affecting their appearance or that may affect their serviceability.

Weight, Color, and Size:* The weight, color and size shall be as shown in Table VI. Colors must be similar to samples in the purchasing office.

TABLE VI—SPECIFICATIONS AS TO WEIGHT, COLOR AND SIZE OF WOOL BLANKETS

Type	*Color*	*Size (in.)*	*Tolerance (in.)*	*Weight (lb.)*	*Tolerance (oz.)*	*Use*
A	Blue	90x66	±2	3½	±4	Patients' beds
B	Green	84x66	±2	3	±3	Nurses', Interns'
C	Blue	60x42	±2	1½	±2	Cribs

Edge Finish: Both ends of the blanket shall be whipstitched with mercerized cotton thread of the same color as the blanket. The stitching shall be formed of at least three threads and shall be of such type that the breaking of any thread will not cause raveling. The depth of stitching shall be not less than $\frac{3}{16}$ inch nor more than ¼ inch. There shall be not fewer than 12 nor more than 15 stitches to the inch.

Corners: Starting 2 inches from each side of each corner the material shall be rounded to a depth of ¾ inch. Edge stitching shall extend ½ inch along the selvage beyond this cut.

Thread Count: The thread count shall be not less than 34 per inch in both warp and filling.

Tensile Strength: The breaking strength shall be not less than 50 pounds for the warp and 45 pounds for the filling.

Type: The blankets shall be single blankets.

Discussion: The Federal Specification DDD-B-421 for part wool blankets has been used as a basis for these specifications. This government specification gives no instructions as to edge finish. Experience has shown that when it is not specified, a poor edge finish may be supplied that will not be serviceable. The government specification likewise omits the tensile strength requirement and the thread count (25 by 20) has been withdrawn as being impractical. The foregoing specifications, therefore, recommend the thread count and tensile strength required in the navy specifications for all wool blankets.

The size of the blanket required may be calculated by the following formulas:

Hospital Beds

Length
- Length of mattress
- Less 10% of mattress length (at head)
- Depth of mattress
- 10% of mattress length for tuck-under
- Plus 10% of above sum for shrinkage

*Standard Sizes of Bed Blanket

Length	Width	Length	Width
76	54	84	66
76	60	90	66
80	60	80	68
84	60	80	70
76	64	84	72
80	66	90	80

(United States Department of Commerce, Simplified Practice Bulletin No. 11, Bed Blankets, 1924.)

Width
Width of mattress
2 x depth of mattress
25% of mattress width for tuck-under
Plus 10% of above for shrinkage

Personnel Beds

Length: The above formula may be used except that 6% of the mattress length will be sufficient tuck-under.
Width: The above formula may be used.

The choice of color conforms to the general color scheme of the hospital, blue for patients and green for personnel. Dark colors were ruled out because of their unattractiveness, and white because of its higher cost.

No allowance has been made in either sheet or blanket length for the needs of orthopedic beds with special apparatus.

Cotton Blankets

Grade: The blankets shall be of the grade commercially known as firsts.

Material: The blankets shall be of 100 per cent cotton, thoroughly cleaned and free from specks, seeds and other impurities.

Workmanship: The blankets shall be free from imperfections of manufacture affecting their appearance or that may affect their serviceability.

Weight, Color, and Size: The weight, color and size shall be as shown in Table VII.

TABLE VII—SPECIFICATIONS AS TO WEIGHT, COLOR AND SIZE OF COTTON BLANKETS

Type	*Color*	*Size (in.)*	*Tolerance (in.)*	*Weight per Sq. Yd. (oz.)*	*Tolerance (Per Cent)*	*Use*
D	White	90x70 or 72	−2, any plus	5	±4	Bath
E	Pale blue and white*	36x36 or 36x40	±1	6	±4	Bassinet

*Any other light color may be substituted if a sample submitted is satisfactory to the purchaser.

Edge Finish: Type D blankets shall have both ends whipstitched with mercerized white cotton thread, stitching to consist of two or more threads, and to be of such type that the breaking of any thread will not cause raveling. The depth of stitching shall be not less than three-sixteenths inch, and the threads securely fastened.

Type E blankets will be preferred with the same edge finish as the foregoing but bids may also be submitted for blankets with the edges hemmed. The hems must be stitched with a mercerized cotton thread to match the blanket, and must be not less than one-fourth nor more than three-eighths inch wide.

Weave: The weave of the type D blankets may be either twilled or plain. Type E blankets shall be supplied in a twilled weave.

Sample: Purchase will be made on the basis of a sample submitted.

Discussion: There appears to be no government specification for sheet blankets. The foregoing standards, however, seem in the light of practical experience to cover the essential requirements.

The standard sizes for bassinet blankets are 36 by 45 inches, 36 by 50 inches, and 38 by 50 inches. The one most commonly used is 36 by 50 inches. The usual size of a wrapping blanket is 30 by 40 inches. In this hospital, however, the nurses prefer for purposes of economy to use the same size blanket for the bassinet and for wrapping, which explains the specification of a nonstandard size.

Wash Cloths

Weave: The cloths shall be terry weave, single loop construction.

Color: The color shall be white or as specified at the time of purchase.

Size: The size shall be 12 by 12 inches finished, with a variation of one-half inch allowable.

Edge: Edge stitching shall be uniform and well fastened.

Note: Purchase will be made on the basis of a sample submitted.

Discussion: Since loss, rather than wear, is the factor to be considered in the cost of wash cloths, it is unnecessary to give detailed specifications. If the purchase is made from sample, it will be possible to obtain a sufficiently substantial material to stand the strain of laundering for the brief life of a wash cloth.

Bath Towels

Grade: The towels shall be of the grade commercially known as "firsts," except that arrangements may be made to accept "seconds" up to 10 per cent of the shipment at a discount in price. Bidders shall specify in their proposals the discount which they propose to allow for "seconds." The "seconds" shall be properly marked and packed separately. The defect which classifies them as "seconds" shall be such that it will not materially affect the appearance and serviceability. They shall otherwise be of the same construction as the "firsts."

Material: 1. The towels shall be made of thoroughly bleached cotton, thoroughly cleaned and free from waste, uniformly woven and free from avoidable imperfections of manufacture.

2. The weave shall be terry weave, rib construction, except for a border of plain weaving not to exceed 3 inches on each end. They shall be woven with double loops or with two-ply yarn in single loops.

3. The thread count shall contain not less than 84 ends (top and bottom warp included) and not less than 42 picks per inch.

4. The breaking strength, by the grab method,

shall be not less than 40 pounds for the warp and 45 pounds for the filling.

Construction: 1. The size of the towel shall be 40 by 20 inches finished, with a plus or minus tolerance of one inch in length and one-half inch in width.

2. The weight shall be at least six pounds per dozen.

3. The hems shall be at least one-fourth inch wide and backstitched at the corners, shall be stitched with No. 36 white cotton thread, and shall have no raw edges showing.

4. The towels shall have tightly woven fast selvages at least one-half inch wide.

5. A colored stripe 1½ to 2 inches wide shall be woven through the center of the towel for the weaving of the name of the hospital in white block letters. The lettering shall be not less than one-eighth inch inside the colored stripe in the center.

6. The color of the towel shall be white except for the colored center stripe as described above.

Note: The sample submitted and a towel taken from each case on delivery will be laundered by the hospital to ascertain whether the stripe and the towel will shrink evenly.

Discussion: The foregoing specification is based on Navy Specification 27T3a (1932).

Grade: It is customary in the purchase of name woven towels to accept "seconds" up to 10 per cent of the shipment at a discount price, since the manufacturer has no other outlet for goods showing slight imperfections, which may be unavoidable.

Tensile Strength: The government tensile strength requirement is 40 by 30, which is lower than a laboratory check of several standard brands in the rib construction. This check would seem to indicate that a requirement of 40 pounds for the warp and 45 pounds for the filling is not too high.

Size: The size specified is ample for bathing patients. A larger size might be preferred for personnel use because the motion used in drying is different from that when patients are bathed in bed. The next larger size (44 by 22 inches) will cost more and will be 20 per cent heavier to launder.

Weight: A representative number of towels meeting these specifications in other respects averaged 6.2 pounds per dozen.

Color: The stripe is blue for patients' towels and green for those used for personnel, in harmony with the general color scheme for textile supplies.

Laundry Test: Experience has shown that uneven shrinkage may cause the stripe to be tighter or looser than the body of the towel.

Table VIII—Standards for Yardage

Item	*Color*	*Width (in.)*	*Thread Count*	*Tensile Strength*	*Wt. per Sq. Yd. (oz.)*	*Uses*
1. Bird's-eye	White	20 27	60x44 ±2		4.0	Diapers
2. Damask, table	"	64	Rosemary Basco, Grade No. 100			Tablecloths
3. Drill	Unblchd.	36	72x62 ±2			Kitchen aprons, bed pan covers
4. Flannel, Canton	White	36				Hot water bag covers, patients' moccasins
5. Flannel, outing	"	27 36	Twilled Weave			Childrens' gowns, surgical hose, general use
6. Indian Head	" Colored	36				Scrub gowns, screen covers, table linen
7. Lawn	White	36	64x68 ±2			Nurses' operating caps
8. Padding, quilted	"	36	66x56 (cover)	Stitching ½" apart Covering bleached Edge bound Cotton bleached		Personnel mattress pads, crib pads
9. Marquisette, curtain	Ecru	36	8-4 ply yarns x 9-4 ply yarns			Nurses' residence curtains
10. Sheeting	White	36	76x68	70x70	4.6	General use
11. Sheeting	Unbl.	36	62x62		4.2	Binders Operating clothing (except gowns) Patients' clothes bags general use
12. Sheeting	Unbl.	72	56x60		4.0	Shrouds, slings
13. Sheeting	"	72	60x60		14.5	Surgery wrappers
14. Sheeting	"	36 72	68x72		4.6	Gowns Surgery drape sheets
15. Terry Cloth	White	18				Children's bibs
16. Ticking	Blue & White	36	78x62	135x90	9.0	To recover pillows
17. Towelling, crash (cotton)	Colored Borders	17	40x30			Kitchen towels, surgery towels, laboratory towels
18. Towelling, twill (cotton)	Blue Border	14				Dressing towels

Huck Towels

Grade: The towels shall be of the grade commercially known as "firsts," except that arrangements may be made to accept "seconds" up to 10 per cent of the shipment at a discount in price. Bidders shall specify in their proposals the discount which they propose to allow for "seconds." The "seconds" shall be properly marked and packed separately. The defect which classifies them as "seconds" shall be such that it will not materially affect the appearance and serviceability. They shall otherwise be of the same construction as the "firsts."

Material: 1. The towels shall be made of thoroughly bleached cotton free from waste, and free from avoidable imperfections in manufacture.

2. The weave shall be that known as huck except for a border at each end.

3. The thread count shall contain not less than 52 ends of 2-ply yarn per inch in the warp and not less than 26 picks of 2 threads per inch in the fill-

ing. A 2-ply yarn with a slight amount of ply twist can be used in place of the 2 single yarns in the filling if desired.

4. The towels shall not contain more than 5 per cent of sizing materials.

Construction: 1. The finished size of the towels shall be 32 by 17 inches, with a plus or minus tolerance of one inch in length and one-half inch in width.

2. The weight shall be at least 2 pounds 5 ounces per dozen.

3. The hems shall be at least one-fourth inch in width and backstitched at the corners, and shall have no raw edges showing.

4. The towels shall have tightly woven fast selvages at least one-fourth inch wide.

5. A colored stripe 1 inch wide shall be woven through the center of the towel for the weaving of the name of the hospital in white block letters three-fourths inch high. The color to be used will be specified at the time of purchase.

6. The towel shall be white except for the colored stripe as described above.

Note: The sample submitted and a towel taken from each case on delivery will be laundered by the hospital to ascertain whether the stripe and the towel will shrink evenly.

Discussion: Federal Specification DDD-T-531 (1931) has been used as a basis for the specifications for huck towels.

Standards for Yardage

On the preceding page appears Table VIII which gives standards for yardage for eighteen materials. A brief discussion of the materials follows:

Discussion: Bird's-eye: These requirements are based on Federal Specification No. 612, which has been checked against samples of standard brands.

Damask, table: For institutional use Basco has become established as the standard substitute for linen. In this instance specification by brand name cannot be avoided.

Drill: This is chosen for kitchen aprons and bedpan covers because it is more or less impervious to moisture and is less conspicuous than the striped ticking frequently used.

Canton flannel: This material, used with the napped side out, makes a stronger and warmer covering for hot water bags than does outing flannel. A moccasin made of Canton flannel with the twilled side out makes an excellent substitute for bedroom slippers. It is inexpensive and easily washed.

Cotton suiting: Under the trade name of Indian Head this is a standard product of high grade. Other fast color fabrics on the market would give satisfaction.

Marquisette: Curtain material of this construction is more durable than the usual marquisette and, because of its coarse open mesh, admits more light.

Sheeting: Various grades and weights of sheeting are required. No. 10 and No. 14 are of the same construction as that called for in the specifications for sheets. No. 11 is a lighter weight material that is less expensive and seems satisfactory for general use. No. 12 is a thin material that is cheap and can be used where durability is not an important factor to be considered. No. 13 has been chosen for surgery wrappers because its weight and closeness of weave make it especially suitable for this purpose.

An effort has been made to combine items in this yardage list so that fewer need be kept in stock. The foregoing list of eighteen materials covers most of the requirements of the sewing room. If bassinet sheets and draw sheets are to be made rather than bought, sheeting in the proper widths of type 10 or 14 would be added to the list.

Making Use of Sewing Room

The use of the hospital sewing room to make nonstandard articles or those that are used in small quantities is sometimes an economy. The policy of this hospital as to which are made and which bought varies with circumstances.

A vocational school maintained by the public school system has been of great value in augmenting the labor available in the sewing room. The hospital furnishes the material and the school supplies the labor at a charge only sufficient to cover the cost of needles, thread and other small supplies. The hospital profits by having a source of unpaid labor, the school by having material to work on. Since it aims to train girls for factory sewing, it must have orders of factory size. The school has a picoting machine and has put a picot edge on the diapers. This is less bulky than a hem, is quicker to make and is equally durable. It has been suggested that a similar finish might be used to advantage on table cloths, surgery wrappers and certain of the towels.

There are more than 150 items in the hospital linen inventory, only a part of which are shown in the foregoing specifications. Some, such as bedspreads and bathrobes, have been omitted because taste and individual judgment will determine the choice for each institution, and specifications will therefore have little general interest; others, such as rubber sheeting and textiles used in the laundry, because they seemed to be outside the scope of this report. It seems evident that the subject of institutional textile supplies is one that needs continued intensive study.

The Institutional Hospital

By FRANCIS WILLARD PUCKEY and AUSTIN D. JENKINS
Architects, Chicago

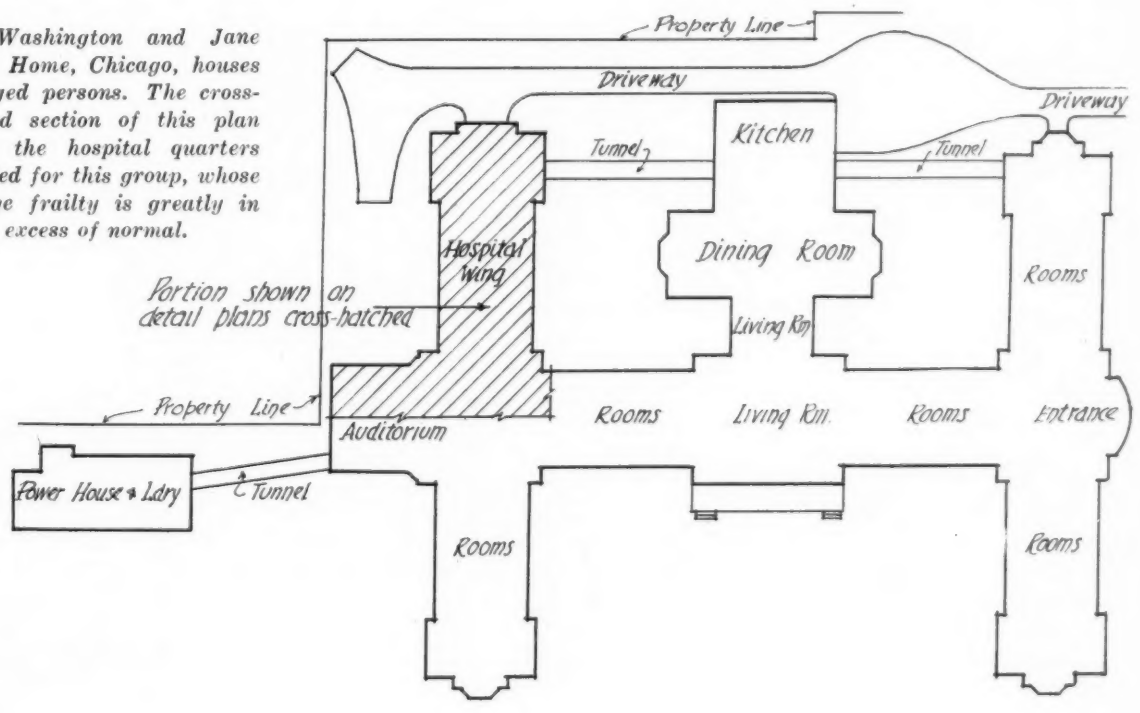
ANY institution designed for the continued residence of a large group should have adequate hospital facilities, the layout and arrangement suited to the peculiar needs of the residents. Provision for hospitalization should be considered from the first in the development of the plans and the medical staff should be given every opportunity to advise and direct as to such provision. Extremely valuable is a study of hospital space in similar institutions to discover points in plan which experience has shown to be desirable or faulty.

Among the advantages to the institution from the inclusion of proper hospital space in its plan may be mentioned the following.

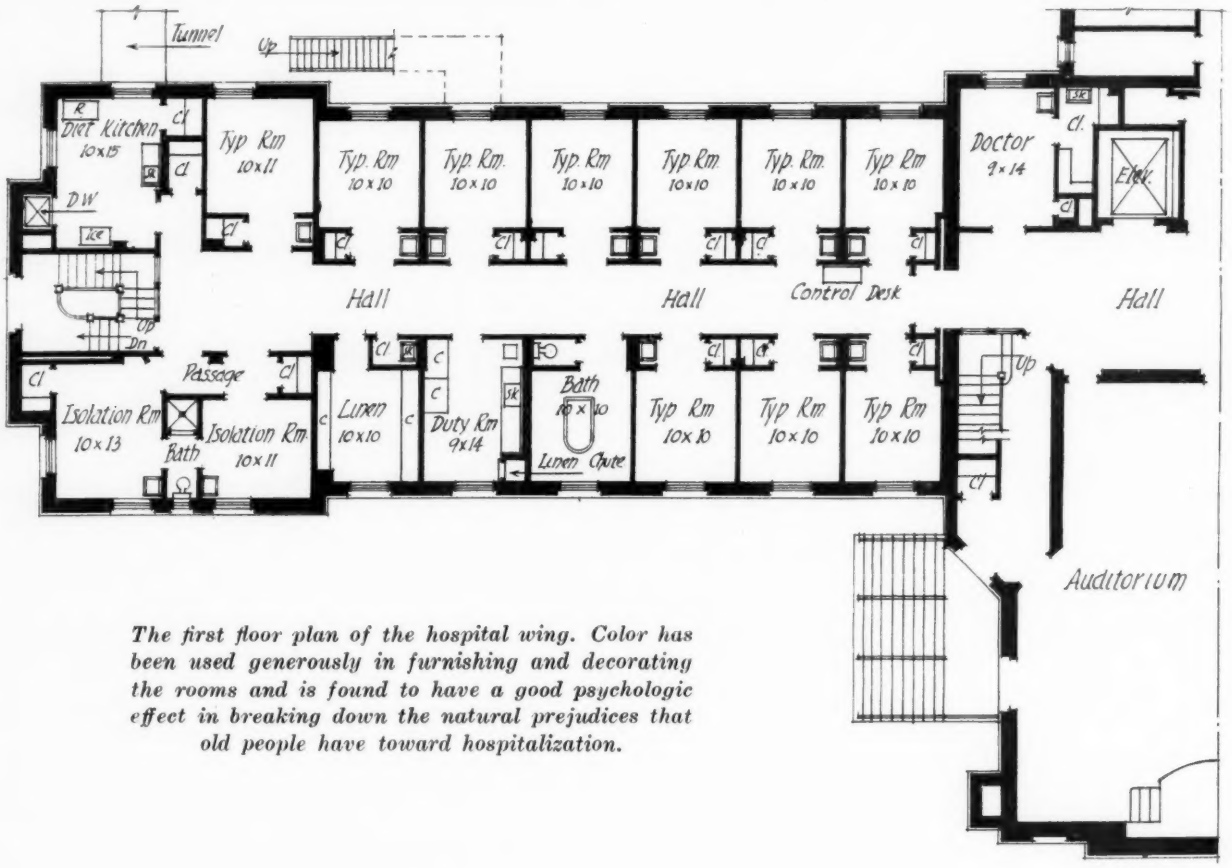
1. Economy through the elimination of outside hospital charges.
2. Prompt performance of emergency operations.
3. Ability to isolate promptly cases of severe colds, influenza and any other contagious diseases.
4. Reduction in construction costs of hospital space, if made part of a much larger building operation.

Generally speaking, the hospital space should be in a separate wing of the institution. Its orientation should provide direct sunlight in as many rooms as possible. An elevator sufficiently large for a wheel cot should be adjacent. There should be convenient connection between the diet kitchens and the main kitchen, which should be at a reasonable distance from the hospital. Single rooms are for many reasons preferable to wards, particularly in the care of the aged. The furnishing and decoration of the rooms should be as cheerful and noninstitutional as possible. Solarium space is desirable. An inconspicuous entrance and driveway should be provided for the use of the undertaker, and the morgue should be preferably in the basement, convenient both to the elevator and this entrance.

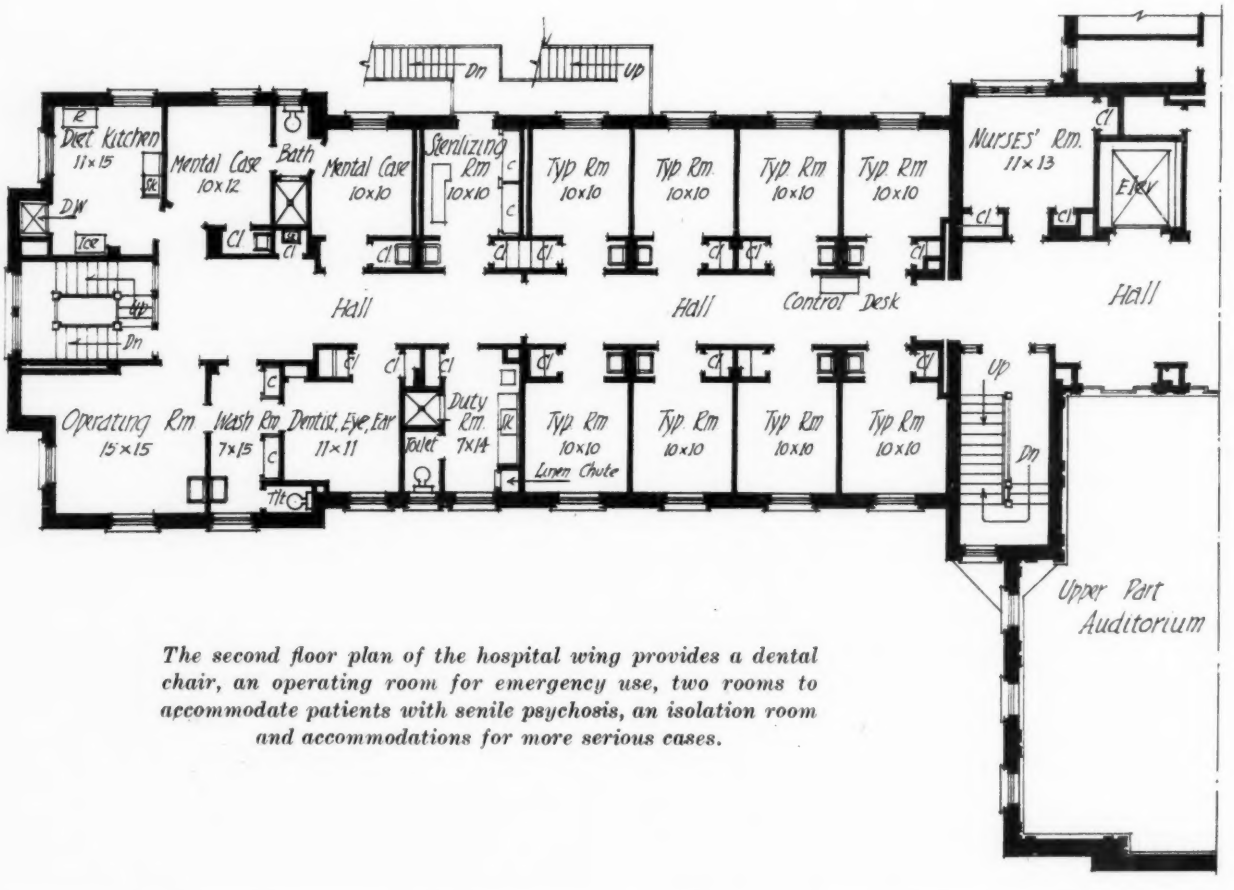
The accompanying plans show the hospital wing built as part of the new building of the Washington and Jane Smith Home, Chicago, an institution for the care of 150 aged residents of both sexes. The Smith Home has now been in its new quarters for three years and the hospital layout has been thoroughly tried out. The medical director of the home, Dr. William L. Gregg, has been kind enough to give us his conclusions based on this period of



The Washington and Jane Smith Home, Chicago, houses 150 aged persons. The cross-hatched section of this plan shows the hospital quarters provided for this group, whose average frailty is greatly in excess of normal.



The first floor plan of the hospital wing. Color has been used generously in furnishing and decorating the rooms and is found to have a good psychologic effect in breaking down the natural prejudices that old people have toward hospitalization.



The second floor plan of the hospital wing provides a dental chair, an operating room for emergency use, two rooms to accommodate patients with senile psychosis, an isolation room and accommodations for more serious cases.

the hospital's operation. These are as follows:

1. The dental chair is much used by the residents. A dentist is in attendance a full day each week or oftener.

2. Frequent occasion arises for eye and ear work and a specialist comes in as needed.

3. While the operating room has not often been used for major surgery, it has been invaluable in handling emergencies such as frequently arise in a home for the aged, such as emergency bladder drainage. Occasional serious emergencies indicate the necessity of operating room equipment and nursing force adequate to handle major operations.

4. Cases of senile psychosis are comparatively frequent. The two rooms for mental cases have been invaluable. These rooms are furnished and arranged so as to make self-inflicted injuries difficult and proper supervision easy.

5. The use of color in furnishing and decoration of the rooms has been found to have an excellent psychologic effect in breaking down the natural antipathy that old people have to hospitalization.

6. The solarium on the third floor of the hospital wing is much used.

7. No cases have been taken to outside hospitals.

8. X-ray facilities were, after much consideration, omitted from the layout. A portable machine brought in from the outside has been found reasonably satisfactory. Space in the third floor, with electrical connections, is ready for this equipment when needed.

9. A force of three nurses is adequate. The nurses' living quarters are in the south wing of the home. A nurse off duty is thus removed as far as possible from her job. A room provided on the first floor for use by the nurses in changing into their uniforms was found unnecessary and is now used as a dressing room.

10. To supplement the hospital equipment there has been built up within the institution a so-called "out-patient department," residents of the home coming to the hospital for minor ailments such as colds and intestinal complaints. Routine medication and instructions are given. The head nurse follows up the case of each resident, and if high temperature or rapid pulse develops, the patient is at once taken to the hospital. During the month of April, for instance, 167 such calls were made on residents in their rooms. This procedure has greatly reduced cases of serious illness, particularly pneumonia. During nine years of operation of the home with an average of about seventy residents only four deaths from pneumonia have occurred.

11. The "gallery openings" from the hall west of the hospital into the auditorium make it possible for ambulatory cases to witness entertainments. This feature has been the source of much pleasure and benefit.

12. Sound deadening material should have been used on the corridor ceilings, as without it the corridors are noisy. With the exception of the corridor noise, three years' use of the new hospital wing has shown the arrangement and equipment entirely satisfactory.

These conclusions are, of course, based on an institution designed particularly for the care of the aged and would not all apply to an institution ministering to a different class. Details of arrangement and equipment would necessarily vary, but the results obtained here should be of service in studying hospital plans for almost any type of institution.

Comments by Mr. Van Arsdall

H. P. Van Arsdall, Samuel Hannaford & Sons, Cincinnati, was asked to read the article and submit comments. He makes the following suggestions.

"A careful study of the accompanying plans reveals a type of hospital planning which is quite unusual and certainly is a radical departure from accustomed practice. A critic sitting in judgment of another's work is considerably handicapped when forming an opinion, owing to his ignorance of the plan as a whole and the various administrative problems that influenced the layout. However, since the architects state that three years' use of the new hospital wing has shown the arrangement and equipment to be entirely satisfactory, I shall confine my remarks to a few questions only.

"On the first floor, why wasn't there provided (1) a wheel chair and stretcher car storage space, (2) a visitors' waiting room, (3) male and female public toilet rooms, (4) an incinerator, and (5) possibly a nurses' rest room with toilet facilities?

"As there is only one bath shown for the use of normal patients, was it the intention to admit only male (or female) patients to this floor?

"In connection with and opening directly into the bath there is shown a single water closet compartment. As this closet is the only one shown for the use of normal patients on the floor, may I inquire if this arrangement is satisfactory? I should think one water closet insufficient and should suggest that the compartment be separate and distinct from the bath. Might it not be well for sanitary reasons to include a lavatory in a room occupied by water closets?

"The location and arrangement of the isolation suite seem to be splendid, provided the shower bath has proved satisfactory for the use of very sick patients. The duty room appears to have been well located to prevent the transmission of noise

to other portions of the building. It is unfortunate that the corridor stair enclosure prevents the free circulation and passage of fresh air through the center hall; maybe mechanical ventilation is provided.

"Many of the questions concerning the first floor arrangement apply to the second floor as well and I shall not repeat them.

"Since there are two operating rooms (a major and a minor) on this floor, would it not have been better to have placed the sterilizing room between them and to install the scrub-up sinks in the large hall space? This arrangement would of necessity require the moving of the eye, ear and dental room a few feet toward the auditorium, and the relocating of the duty room in the space now occupied by the sterilizing room. (The first floor duty room would also have to be moved to the other side of the hall on account of plumbing pipes and the linen chute.) If this change were carried through there would be space available for a patients' bath and toilet room, which is apparently not now provided."

Victor J. Klutho, St. Louis architect, to whom the article and plans were also submitted, writes as follows: "The arrangement of the hospital wing is so well studied and planned that little room is left for improvement. The location has been well selected. It is practically isolated from the home, which is very good planning for an institution of this kind."

Mr. Jenkins Answers Questions

Says Austin D. Jenkins, speaking for his architectural firm, in response to the comments by Mr. Van Arsdall and Mr. Klutho:

"Mr. Van Arsdall's comments are most interesting. The minimum age of the residents in the Smith Home is 65 years and many are very much older. Many of the unusual features of the plan arise from the experience of Doctor Gregg, the physician in charge, in caring for a group whose average frailty is greatly in excess of normal.

"Wheel chair and stretcher storage space is in the basement adjacent to the elevator, as is the mortuary.

"Visitors enter the home at the main entrance in the south wing, where ample reception room space is provided. They are escorted to the infirmary from there.

"An incinerator is provided in the basement under the kitchen and is reached from the infirmary through a dumb-waiter to the tunnel. The nurses' rest room is on the second floor over the doctor's office. Living quarters for the nurses are in the south wing.

"Patients are escorted by the floor nurses to bath and toilet on all occasions. This prevents conflict of sexes in the use of bath and toilets. In the large majority of cases bedpans are used. Serious cases requiring the use of the bedpan are placed on the second floor. Inclusion of a lavatory in the toilet room is a good point. I believe it should have been there.

"The corridors and all toilets are mechanically ventilated.

"On the second floor the instrument sterilizer is in the operating room. General sterilization of bandages and the like is done in the sterilizing room. The change suggested by Mr. Van Arsdall might well have advantages. The arrangement shown was suggested by the resident physician."

Should the Hospital Morgue Be Open Both Day and Night?

It is the duty of the hospital to provide for the public efficient service of all kinds. This includes the effective study and treatment of patients, and also the application of humane principles in the handling of the relatives of persons who have died in the hospital. But there is a limit to which this generous spirit of cooperation should go.

It was customary in a certain institution to deliver bodies to local undertakers at any time of day or night at which they might be requested. This necessitated a rather careless technique of receipts for bodies, particularly during the night hours.

As a result of this practice, several disturbing errors took place, such as an interchange of names leading to the delivery of the wrong body to the undertaker. Consequently, the hospital decided that its morgue would be open for the delivery of bodies only from 8 a.m. to 6 p.m. The local undertakers protested against the plan and the hospital board of trustees was accused of having adopted an unfair course.

It is well known that undertakers frequently are offensively selfish in their attitude toward the hospital. They desire the cooperation and aid of the institution without reciprocating in any way. It matters little to some of them how difficult is the work of the hospital and to what additional effort the institution must go to accommodate them. Many undertakers show their lack of gratitude by always opposing the granting of postmortem permissions.

There is no sound reason why a hospital should be required to deliver the bodies of deceased patients to the undertaker at all hours of the day and night. In certain instances where a body is to be transported a long distance, it may be necessary to permit its removal at irregular hours, but the rule regarding removals should be broken only on rare occasions. It is to the interest of both the hospital and the relatives of the deceased to adopt a procedure that will permit bodies to be removed only during daylight hours, and to refuse to accommodate a self-seeking undertaker by breaking the rule, except in emergencies.

The Hospital's Part in Training Specialists

By J. S. RODMAN, M.D.
Medical Secretary, National Board of Medical Examiners, Philadelphia

THE problem of the proper qualification of the specialist and other questions growing out of it such as the designation of the specialist when qualified, whether the state should legally take the matter over or whether the medical profession should put its own house in order, have occupied much of the time and program of medical meetings dealing with educational matters. As has been true of medicine always, the desire to improve itself has been the impelling force back of this problem. All have recognized the need for properly qualifying and certifying specialists so that the public can readily know where to turn should the need arise. There is far too much work done badly, although legally, by the specialist with totally inadequate training. The chief difficulty has lain not in a lack of appreciation of the needs of this matter but in finding some workable plan to accomplish it.

Four Specialties Have Led Way

During recent years when some suitable plan was being looked for to which the general medical public and the specialists themselves might agree there have been quietly and efficiently working examining boards in certain specialties whose efforts have already gone far to improve matters in the specialties they represent. In the order of their organization there are the American Board of Ophthalmology, the American Board of Otolaryngology, the American Board of Obstetrics and Gynecology and the American Board of Dermatology and Syphilology. The first three have now had considerable experience in examining candidates, the last is just beginning to function. Some of the leaders of these specialties as represented in the membership of these boards have themselves suggested that while each specialty has problems of training peculiar to itself, many problems are common to all. The thought of other organizations interested in this matter was therefore solicited in order that there might be some guiding body created the functions of which would be purely advisory but which could and would help in this complicated problem.

The organizations, other than the already existing specialty boards, whose cooperation was asked for to establish such a body were the Association of American Medical Colleges, the National Board of Medical Examiners, the Federation of State Medical Boards of the U. S. A., the American Hospital Association and the council on medical education and hospitals of the American Medical Association. This cooperation was forthcoming and so at an organization meeting held February 11, 1934, the Advisory Board on Medical Specialties came into being.

Purpose of New Organization

The purpose of this body is to act in an advisory capacity to such organizations as may approach it concerning the coordination of the education and certification of medical specialists. No action taken by this board shall be binding upon member organizations. The original membership consisted of two members of each of the specialty boards mentioned and two members of each of the organizations also listed.

It was seen that one of the first duties of such an advisory board would be to decide upon the fitness of other specialty boards, as they are organized, to represent their given specialty as well as the probable fitness of their personnel to conduct qualifying examinations. It was determined therefore that to be eligible for membership on the advisory board "an examining board in a specialty must be composed of members elected from or appointed by societies recognized by the advisory board as national societies in that specialty together with representation from the related section of the American Medical Association. Upon being accepted by the advisory board, the newly organized examining board in question will then be recommended to the American Medical Association as being qualified for recognition by that association." There is therefore no conflict between the function of the advisory board and its parent body, the A. M. A. Rather is the work of this board planned to enable the A. M. A. to discriminate in its actions should it see fit to do so. It would seem that there should be none better qualified among the other membership of this parent body to determine the general fitness of a specialty board to function than specialists themselves, with the help of those other bodies particularly interested and concerned with undergraduate and graduate qualifications.

In order to carry on its business the advisory board has elected officers and an executive committee. It has appointed a committee on standards and examinations whose recommendations will be referred to the executive committee and then to the board for approval. The standards and examinations committee has a large program ahead of it. It is to this committee that new specialty boards are referred after their application for representation on the advisory board has been received.

In addition to the specialty boards mentioned as original members of the advisory board other specialty groups have become active in organizing such boards. The pediatricians, radiologists, orthopedists, urologists, neurologists, psychiatrists, proctologists and gastro-enterologists have all served notice on the advisory board that examining boards are being organized in these specialties and that when organization is complete each of them expects to apply for membership in the advisory board. Of these the American Board of Pediatrics has completed its organization, has been approved by the advisory board and has been admitted to membership. The American Board of Radiology has completed its organization and undoubtedly will receive full approval by the advisory board shortly. The next meeting of the advisory board will probably learn that other groups among those mentioned have made headway and some may be ready to be considered at that time.

Much has to be done by the advisory board in initiating its service. Such questions as defining the special fields suitable for specialization, the minimum basic and professional requirements to be asked of all candidates, suggestions as to further training to be exacted of those in each specialty field are matters already taken up for study.

Two Ways of Qualifying as Specialist

One of those groups to be found in the original membership of this board is the American Hospital Association. The hospital has long since ceased to be a boarding house for the sick and has become an indispensable part of both undergraduate and graduate medical education. In general there are two ways by which one may become qualified in a specialty: Plan I calls for a further period of study in the graduate school of a university, and Plan II is the apprenticeship system, in which a number of years are spent in actual work in the specialty under the guidance of one already recognized as a qualified specialist in the field.

A number of graduate schools in medicine are already doing splendid work in training specialists, the University of Minnesota, the University of Pennsylvania, Columbia University and Harvard, to mention only a few. Short courses are given in specialty fields by certain other medical schools.

In a country as large as ours, however, it is unlikely that for some time to come any large part of the required number of specialists can be trained in this way. The larger number will follow Plan II and secure their training through the apprenticeship plan. In both of these plans the hospital is a vital and indispensable unit.

The council on medical education and hospitals has approved as acceptable for the training of interns in general medicine 677 hospitals with a bed capacity of 212,578; 360 hospitals have been approved for residencies. These 360 hospitals have provided opportunities for 2,299 graduates to become trained in special fields. The following table may be of interest to persons in the hospital field.

NUMBER OF HOSPITALS APPROVED FOR RESIDENCIES IN SPECIALTIES

123	hospitals approved for residencies in medicine
132	hospitals approved for residencies in surgery
87	hospitals approved for residencies in psychiatry
83	hospitals approved for residencies in pediatrics
43	hospitals approved for residencies in orthopedics
63	hospitals approved for residencies in pathology
36	hospitals approved for residencies in obstetrics
47	hospitals approved for residencies in obstetrics and gynecology
57	hospitals approved for residencies in ophthalmology and otolaryngology
60	hospitals approved for residencies in tuberculosis
37	hospitals approved for residencies in urology
40	hospitals approved for residencies in radiology

Additional opportunity has been provided in other special fields such as anesthesia, cardiology, communicable diseases, dermatology and syphilology, epilepsy, fractures, industrial surgery, leprosy, malignant diseases, mental deficiencies, metabolic diseases, mixed residencies, neurology, thoracic surgery and tropical medicine.

It is entirely too soon to speak of the length of hospital service that should be required and the type of training to be expected. These matters must be given careful thought on the part of the advisory board before its recommendations are passed on to the council on medical education and hospitals of the A. M. A. and the specialty boards.

The hospitals that have already done yeoman work in the training of graduates for general practice and in the various special branches will find an enlarged field of usefulness awaiting them in cooperating fully in this effort to supply the public with adequately trained specialists only. This will mean additional equipment, additional beds and staffs that can teach. Perhaps the time will come before long when the hospitals will require qualification by the specialty boards represented in the advisory board before electing specialists to their staffs.[1]

[1]Read before the convention of the American Hospital Association, Philadelphia, Sept. 26, 1934.

What Part Nursing

By ANNIE W. GOODRICH, R.N.
Dean Emeritus, Yale University School of Nursing, New Haven, Conn.

WHATEVER the future may bring, and inevitably scientific methods and concepts will increasingly permeate educational programs from the nursery school on, the educational foundation still generally accepted as adequate for the student nurse in no wise prepares her for the professional curriculum that modern interpretation of nursing practice demands. The growing appreciation of the interrelationship between mind and body, the influence of the social upon the physical, the averting of mental, physical and emotional disaster call for maturity through study and life experience achieved only through a broad and sound scientific preparation.

Nurse Needs Community Viewpoint

"Know thy community" is this century's command to every nurse, a command that implies the entire gamut of human expressions and experiences. It is concerned not less with the criminal, the delinquent and defective population than it is with the newborn, the school child and the well-to-do. It demands continually to know the how and why. From the ever increasing body of health workers it expects authentic information as to the sores of our civilization, interpretation of their causes and concerted effort for their healing.

The part of nursing in this creative project is of profound significance and presents many facets. Beginning with the plan and program of nursing education, however failing its interpretation, through all the varied aspects of the field, we find a life activity concerned with the family, that least common denominator of social expression, an activity that seeks to achieve for each member those fundamental factors in effective social contribution—physical, mental and emotional balance. Privileged as is no other group, through prolonged and intimate association under varied circumstances and through a complexity of conditions, to study, to gain insight and to influence, the nurse's part today is fraught with possibilities that impose a responsibility upon those who direct her preparation not less great than is imposed upon the individual who selects the field. The great essential of the nurse's education and practice is an understanding of the creativeness of her function from its simplest to its most involved expression.

In the past century nursing has steadily advanced from an emotional expression to a craft, and forward to those levels designated as professional. In so doing it has been a consistent expression, in a full sense of the term, of social evolution in this country and in the twentieth century. For the twentieth century, having explored nature in all its aspects, has now turned attention to the most vital investigation from the social standpoint, that of man.

Nursing has entered upon a distinctly new era but an era entirely consistent with the times. It is indeed in a full sense a social expression of the times, an essential factor in its working plan, a demonstration of the educational program demanded by a democracy not failing but in the making. The great problem of today is the increasing knowledge relating to any given subject, forcing specialization, and the integration of these specialties into a composite contribution. How entirely this applies to every aspect of group life—education, profession, occupation. Within the past half-century there has developed within the health group alone a variety of specialties, the knowledge concerning any one of which is as yet superficial, the contribution of any one of which depends for effective results upon the now many others.

Health Movement May Avert World Disaster

The awakening appreciation of the need of interrelation of all social expressions if the good life is to be achieved finds expression in perhaps no more striking or important form than the institute of human relations, the intent of which is to interweave into a harmoniously integrated working whole social aspects once widely, and in no small measure yet, separated.

Could we but see in its entirety the vast network of health activities, steadily extending and expanding in country after country on every continent, it would present with all its deficiencies and great lapses an advancing host in whose constructive program lies the strongest hope (I think it is the only hope) in averting imminent, impending worldwide disaster.

While we cannot and should not subscribe to the methods through which it came about, the reports of experts in the fields of sociology and health force us to acknowledge the Russian program of

child health and protection as effecting without our resources in personnel and equipment the objectives to which we in precept subscribe, objectives so simply stated to the children of his country by a young Russian engineer.

"We live badly, we change nature but as yet have not changed ourselves and this is the most essential thing. We must root out uncouthness and ignorance. We must change ourselves; we must become worthy of a better life and this better life will not come as a miracle; we ourselves must create it but to create it we need knowledge; we need strong hands, yes, but we need strong minds too."

Implicit in the constitution of our country through the unequivocal insistence on the rights of the individual is the command of social change or readjustment by evolution not by revolution, and this provision is a bequest of inestimable value. But let not the fact be overlooked that it emanated from a discernment of the potential value of each individual to society at large. An individual contribution is of little value, be the expression what it may, that does not coalesce with group life.

A historical review of the evolution of the hospital and the growth and development of the groups that function in the health field will reveal, whether it be in the institutional care of the sick or in the broader program of public health nursing, changes in social attitudes not less than in physical conditions that are in consistent accord with democratic principles.

Children's Charter—An Important Document

However failing we may be we have in the Children's Charter the most evolutionary of human pronouncements, a pronouncement however of but little value except as one after another its nineteen tenets are realized, the fifteenth[1] of which alone would within a decade metamorphose our civilization. Nor is such realization without the bounds of achievement, for it should be appreciated that that charter could only have been written by those who were already concerned to bring about the conditions which are asserted as the rights of the child, and that their work undoubtedly strengthened by those cryptic conceptions is going steadily, if in many places imperceptibly, on.

I have no fear for the future of nursing if nursing unceasingly strives for the means through which its potentialities may be most fully expressed, but I am convinced that civilizations must rise and fall until the lesson of the importance of the perfection from the standpoint of texture, hue and part of every thread in the great tapestry is learned.

[1] "For every child the right to grow up in a family with an adequate standard of living and the security of a stable income as the surest safeguard against social handicaps."

Like a great tapestry through the vast spaces this industry expresses itself as the simplest craft in the primitive home of the Orient or through the complexities of the modern hospital of our Western civilization enmeshed in which are the beautifying threads of a fine technique.

The most superficial consideration of the subject, "What Part Nursing," reveals a swiftly enlarging pattern of almost indescribable intricacies emerging from this simple, truly primordial, but distinctive expression of human concern and activity. A development entirely consistent, even more insistent than in the past, is the universal unuttered craving for the satisfying life; in short, a life worth living.

It is not possible for me to outline in detail, nor is it within the limits of time or knowledge, a program of procedure, educational or experimental, through which every or any nurse may advance in ordered sequence toward the desired goal.

Home Nursing Is Valuable Experience

It is undoubtedly true in that most valuable of teaching fields, the hospital ward, that the contacts with the individual, whether patient, physician or fellow nurse, are made in a center devoid of accessories that are important factors in an understanding approach. There are advantages in this, but there are also values accruing through the more comprehensive knowledge that includes the environment of all concerned. Again and again have public health nurses, whose clinical experience has been obtained with cases representing the lowest economic level, expressed astonishment, at the sordid wretchedness of the very tenements from which their patients had come. To have read of these conditions, to have cared for individuals removed from such environment, in nowise makes the impress of the personal view of the actual situation. But if we must see to believe, it is not less true that believing is seeing. In research the imaginative is quite as essential as the inquiring mind.

What a marvelous opportunity is accorded the nurse whatever her selected branch! How describe the complexities of her procedures upon which may hang a human life! What laboratories of study, experimentation and research for the scientifically trained mind are those wards of the hospital, those cosmic entities in which by day and by night she may be found acquiring knowledge of which, so varied and so comprehensive are its aspects, no measurement, no adequate interpretation of its content are yet available! What a foundation is given the thinking, inquiring mind for future contribution! The ward and the community, except in area and unit of population, do not

so greatly differ. In that fact lies the strength of nursing education; its great weakness the opening of its doors to unoriented youth.

The fact should not be overlooked that the foundations of nursing education and nursing practice were laid by students selected on the basis of three requirements: maturity, culture and ability. For the first quarter of a century the age of admission was twenty-three and in some schools twenty-five. Socially informed through life experiences, indomitable of will, these women found no task too humble, no demand too great, to further a preeminently woman's project to greater ends than science, except to the favored few, had revealed.

I need not review the weakening of the profession through the strides of medical science which brought about a multiplicity of hospitals for the economic support of which there was no adequate plan and which resulted in the over-development of schools of nursing. Concretely speaking, the task imposed upon the nursing profession today is the releasing of schools of nursing from institutions upon which the burden of their support should not be imposed, the limiting of the number of such schools, and the placing of them where there is assured knowledge that the graduates may effect in the community at large changes as transforming as were the changes wrought in the hospital by those pioneers in nursing.

University Training Valuable to Nurse

I have said that nursing is entering upon a new era. If such is the case the challenge to the forthcoming members of the nursing profession is truly inspiring. None can gainsay that in this vast and beautiful country of ours we have, structurally speaking, conditions and developments through which, under right direction, the attainment of the social state long visioned may still be a reasonable hope. In these great universities, over the threshold of which nurses have now stepped, we have knowledge and sources of knowledge no previous century knew, and in few if any countries is it so universally available.

Again in the increasing understanding of education as a continuous, directing, motivating force throughout the life span, the doors are being widely opened for the replenishment of knowledge, a rekindling of the fires that through the demands of daily life tend to burn low. Institutions for the care of the mentally and physically ill have with marvelous rapidity been erected with increasing consideration of the occupants regardless of their social status, until in many the provision, as expressed in equipment and personnel, far exceeds the finest provisions for the patients of barely two decades ago. Here surrounded by scientific means through scientific findings man pursues the quest of knowledge of himself; here have women as nurses, true to type, played an essential if inconspicuous part.

However, the time has come for a definite reorganization of the personnel of those institutions through which the clinical experience in nursing is to be obtained, a reorganization that will entirely reverse the present and generally accepted ratio of students to graduates, in order that the student may be assured the opportunity of observation and actual experience in the care of cases in all the various surgical and medical conditions required for effective community practice. Moreover, this training must be acquired under constant and qualified supervision. I am only too aware that not as yet has any school secured for the students the program this statement implies, but every year brings us closer to our goal.

Graduate Ratio in Hospitals Increases

An increasing body of graduate nurses in relation to students will be found in greater or less number in our hospitals through the country. Many studies have now been made but more are needed before the important question can be determined of the number of nursing hours per patient required by day or by night from the standpoint of age, condition and diagnosis.

The instruction and supervision demanded for the case experience of the student extend today beyond the acquirement of nursing procedures, skills or techniques, important as these are, for there is an increasing understanding of the impingement of the mental upon the physical and of the social conditions upon both.

A factor of importance in giving nursing students a broad foundation is the knowledge it brings of the ever increasing availability of such means for human betterment as dentistry, occupational and physical therapies, immunization against heretofore prevalent diseases, and the contribution of the social workers. The most superficial survey of needs leaves no question as to the achievements possible through an informed, collective will.

I cannot overemphasize, if the fullest returns from this now accepted and large body of community workers is desired, the importance of a broad, general, educational foundation and an intensive and comprehensive professional preparation. This implies a program of wide scope, the bringing into an integrated whole the required factors, an achievement that demands a broad social vision, great tolerance and organizing ability on the part of all concerned.[1]

[1]From an address given at Colorado Hospital Association.

A Bed Lamp Designed to Give Glareless Illumination

By C. E. FERREE and G. RAND
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IN PLANNING the units to be described in this paper we have recognized the three following uses for a bed lamp: (1) as a reading lamp in homes, hotels and private rooms in hospitals, (2) as a reading lamp in hospital wards where the eyes of patients on the opposite side of the ward must be carefully protected from glare and (3) as a lamp for-making various types of examination of a patient who is lying in bed.

Models will be described that have been designed to give glareless illumination in all these situations and the best distribution of light and brightness that it is possible and feasible to attain in a bed lamp. Provisions are also made for the correction of the light as to color. Further, in the examining lamps, the intensity of light may be varied from zero to full without change in the color or composition of the light; in the size, shape and position of the illuminated area, or in the evenness of distribution of light within this area.

Following are some of the requirements of good lighting by means of a bed lamp: (1) The unit should be at a favorable distance from the face, the reading page and the surface of the bed. This provides for a wide spread of illumination and eliminates the spotlight effect. (2) The light should be well diffused. This greatly increases the spread of the illumination and reduces to a minimum the glare on the reading page and other surfaces. (3) The eyes of the reader and of all persons in the room should be protected from the glare from the opening of the unit. (4) The unit should give a fair amount of general illumination to the room. This carries still further the beneficial effects of spread of illumination and is particularly needed when no other means of illuminating the room is employed, as is often desirable when a bed lamp is used. In producing the wider spread of light the optimum effects are obtained, so far as the general illumination of the room and of the surrounding field is concerned, when the walls about midway between floor and ceiling receive the greatest amount of light and the brightness shades off gradually upward and downward.

The bed lamp here described promises to be of significant service in the hospital. The unit gives glareless illumination (1) as a reading lamp in private rooms, (2) as a reading lamp in wards where the eyes of patients on the opposite side of the ward must be protected from glare and (3) as a lamp for making various types of examination of patients lying in bed

It might seem natural to assume that the brightness of the field of view as background should be uniform. Until recently, overlooking the significance of results which we obtained as early as 1913, we were inclined to make this assumption. These results indicated that the eye's tolerance of brightness is by no means the same for all parts of the field of view. Considered broadly, its lowest tolerance is in the lower half of the field, the next lowest is in the upper, and the best tolerance is in the region of the bounding plane between the two halves of the field. Translated into terms of enclosing surfaces of a room of ordinary height, this would mean that the brightness should be highest on the walls near the midlevel of the room, shading off gradually toward floor and ceiling. The level of maximum brightness would then be near that of the eye and not far removed from the plane of work.

By means of one of the earlier models of the bed lamp under consideration, the highest brightness could be given at will to the ceiling or the walls at any level of height from floor to ceiling. The superior comfort, restfulness and entire naturalness of

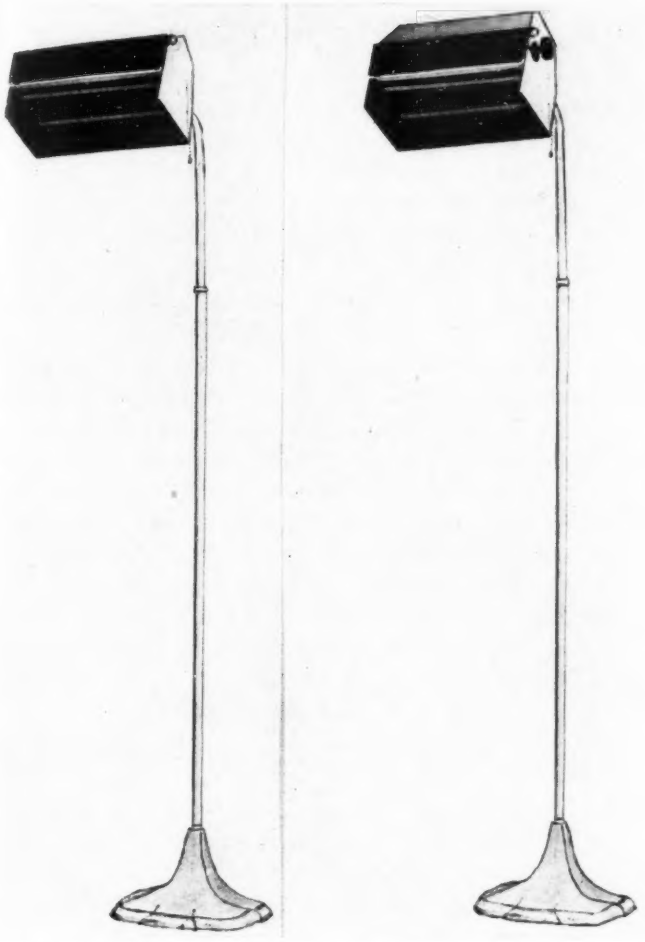


Fig. 1—At the left, a reading lamp for hospital wards; at the right, a combined reading and examining lamp.

the effect produced when the highest brightness was given to the walls midway between floor and ceiling were pronounced and most convincing. This was equally true when the effect was obtained from the position of the reader in bed, or when it was judged by one standing or sitting in the room or viewing it from the outside. When the shift was made to the ceiling or the lower part of the room, the effects produced by the change were uncomfortable, annoying and decidedly unnatural. Only when experienced in sequence could this difference be appreciated to the full. Ordinarily little opportunity is had of making a direct comparison of lighting effects. Because of this, many differences in effect, so great as not to need the aid of tests for their detection, are completely overlooked by the student.

It will be noted in rooms lighted by daylight from windows that, including both windows and illuminated surfaces, the maximum brightness is broadly distributed over the midlevel of the field of view. Because of the small amount of light reflected by the floor and objects in the lower part of the room, the lower part of the field in rooms lighted by windows usually has a low brightness. Lighting by windows, to which the eye has become accustomed through long usage, is a comfortable and restful type of illumination when suitable precautions are taken for protection against glare from the windows themselves.

The first model to be described was designated as a reading lamp for use in homes, hotels and private rooms in hospitals. It may be constructed as a floor-stand unit, it may be clamped to the head of the bed, or it may be mounted on an extensible wall bracket that can be folded back against the wall when the lamp is not in use. It will be described here as a floor-stand unit.

In general the unit consists of a supporting stand and provisions for adjustment, a housing and glare baffle, a diffusing plate and a screen or filter for giving daylight color when desired. The stand has a heavy metal pedestal or base, semicircular in shape so that it may fit closely against the wall.

Centrally positioned near the back of this pedestal is a vertical tubular support provided at its upper end with a split ring and set screw. Telescoping into this upright is a second tube bent into a right angled position at a suitable distance from its lower end. This right angled member is also provided at its farther end with a split ring and set screw. Into this tubing is telescoped a third tube at the end of which on a swivel joint are the lamp and housing.

The first combination of the split ring and set screw provides an adjustment for height and allows the right angled member to be rotated back against the wall when the unit is not in use; the second permits the housing to be set at different distances from the head of the bed. An adjustment of this type is particularly needed in a hospital when the spring and mattress are raised to an inclined position to give the patient greatest comfort in reading. The swivel joint at the end of the right angled member permits the housing to be rotated back against this member when it is turned back against the wall.

Lamp Has Convenience and Versatility

With these adjustments it is easily possible to position the lamp in suitable relation to the face and the reading page, both when the reader is in a recumbent position and when a section of the spring and mattress is raised to an inclined position, and to fold the lamp neatly back against the wall when not in use. These adjustments add greatly to the convenience and versatility of the

lamp, two of the strongest points in its favor.

The housing, made of light brass, is oblong in shape with a suitably rounded top or roof. Its dimensions are 10½ by 6 by 5 inches. The lamp, which may be of any wattage desired within the size limits of the housing, is mounted in a horizontal position near the top of the housing. Across the opening at the bottom and part way up the front of the housing are the glare baffles and just above them is the diffusing plate.

The glare baffles consist of four thin vanes of hard sheet aluminum 10½ inches long and 1½ to 2¾ inches wide. The vanes at the bottom lie in parallel planes in the long dimension of the opening and in the front wall of the housing, and are spread 1½ inches apart. The slant of these vanes is made adjustable to give the proper protection against glare for both the recumbent and the sitting or inclined position of the reader and for the examination of the face, when desired, with the patient in the recumbent position.

Adjustment for Reading in Bed

The egg crate or cellular construction used in our ceiling units[1] and in our desk and bridge lamp was found not to be needed in a bed lamp. Full protection to the eyes of the reader and sufficient protection to the eyes of others in the room can be given without the extra set of vanes set at right angles. The preferred adjustment of the housing for a reader in a recumbent position is slightly in front of the eyes and approximately ten inches above them.

In the use of the unit the intention is to have the opening at the bottom of the housing roughly parallel to the reading plane. This is accomplished by the slant of the housing which is 25 degrees with the vertical.

For reading when patient is in an approximately recumbent position, the vanes across the opening are inclined 48 degrees with the vertical or 23 degrees with the midsection of the housing. For reading in a sitting or inclined position they may be adjusted to suit the individual case. There are three vanes at the bottom but the one of these farthest forward is at the front edge of the housing so that it serves both as a bottom and a front vane, that is, the vanes are in continuous series across the bottom and for two inches upward on the front surface of the housing. In effect, therefore, there are three vanes and three interspaces in the bottom and two vanes and two interspaces in the front surface of the housing.

As already indicated, the vanes, both bottom and front, lie in parallel planes, all subtending the same angle with the perpendicular and the midsection of the housing. This angle is such that the eyes of the reader are protected from all glare from the opening and there is a wide spread of light over the entire bed and its surroundings and over the walls of the room at or near the level of the eyes when the reading position is recumbent. From this region of maximum illumination the light shades off gradually toward ceiling and floor. In all, because of the wide spread of direct light and that reflected from the bed clothing and the enclosing surfaces of the room, a fairly good general illumination is given, sufficient when a 75 or 100-watt lamp is used to permit of reading in the greater part of a bedroom of ordinary size.

In order further to protect the eyes of the reader and others in the room from all glare and high brightness, both surfaces of each vane are painted a flat black. If these vanes were surfaced so as to reflect any considerable amount of light, they would of course themselves give the effect of glare.

Between the vanes, bottom and front, and the lamp is the diffusing plate. For this purpose Belgian flashed opal glass was selected because of its high coefficient both of diffusion and of transmission.

By inserting this plate so that it extends from a position just above the bottom vanes at the back surface of the housing to a position just above the vanes in the front surface, one plate is made to diffuse the light passing between both sets of vanes. The effect of this plate is to eliminate all shadows from the vanes and to give a well diffused, evenly distributed spread of light over a wide area.

Protecting Other Ward Patients From Glare

Despite the fact that reading in a recumbent position is in itself conducive to eyestrain, it is surprising to find how much of the discomfort usually experienced is due to bad lighting. For those who wish to read in bed or those who must read in bed or not at all, this unit will be found almost unbelievably helpful.

The second model of the unit was designed to be used as a reading lamp in hospital wards. It is provided with a thin metal flap that can be turned down over the front vanes or turned up as the occasion may demand. The purpose of the provision is to guard persons who may be in a recumbent position on the opposite side of the room from any possible trace of glare from the front louvers. The flap is supported by a swivel hinge at the top and both ends and is provided with a small knob for convenience of turning. When turned back against the slanting front surface of the housing, it remains in position without any special provision for its retention in that position. The inner surface of

[1] Ferree, C. E., and Rand, G., Glareless Lighting for Hospital Wards, The MODERN HOSPITAL, June, 1932, pp. 128-138; A Glareless Lighting Unit Adapted to the Hospital, Jan., 1934, pp. 57-61.

the flap is painted flat black. When the flap is turned down, the protection to the eyes of those lying in bed on the opposite side of the room is absolute; and while the lighting effects are not so good for reading as when the flap is turned up, they are incomparably better than those obtained from any other bed lamp that has as yet come within our experience. This model is shown at the left of Fig. 1.

Various medical men in hospital service have called our attention to the need for a bed lamp that can be used for examination of the face without disturbing the patient. The patient may be asleep or in a comatose or almost comatose condition. The requirement here is obviously a unit, the light from which can be increased in gradual and continuous change from zero intensity to the amount required for examination or inspection of the face. It is essential, also, that this change should be made without change in the color and composition of the light and it is further desirable that the light be corrected for color in order to give as natural as possible an appearance to the face. We have been able easily and inexpensively to add these two features to the bed lamp described above.

Controlling the Intensity of Light

The correction for color may be obtained by substituting for the flashed opal glass an etched plate of glass having the approved spectral transmission.

As a means of varying the intensity of light a rheostat is utterly unfit. One reason for this is the radical change that is produced in the color of the light. At the low intensities needed for the examination, the light would be of a reddish-orange hue, and further, since this hue would change continuously with change of intensity of light, color correction is entirely impossible. Another reason is that by means of rheostats, as ordinarily constructed, the decrease of intensity cannot be carried in continuous series to zero. Obviously a mechanical means of control is needed.

We have devised such a means which can be used in connection with all local lighting units at little cost and trouble of manufacture. It provides for a decrease of intensity of illumination in continuous series from the full output of the lamp to zero without change in the color or composition of the light; in the size, shape and position of the illuminated area, or in the evenness of distribution of light in that area.

In the case of the present unit it consists of four vanes which extend across the housing in a plane just above the diffusion plate, in such relation to each other that when their flat surfaces are parallel to the beam of light, the maximum amount of light passes through the diffusion plate; and when they are rotated into a position at right angles to the beam, the light changes in continuous series from full intensity to zero.

From Full Intensity to Zero

These vanes are made of thin sheet aluminum and are painted flat black on both surfaces. At the central portion of each end of the vane is attached a pin or shank, at the other end of which is a cogwheel or gear with a diameter of 1¼ inches. The four cogwheels are meshed so that when one of them is turned through 90 degrees, the vanes pass from the position of full light to complete extinction. For convenience in turning, a small knob is attached to one of the cogwheels.

The diffusion plate is directly beneath the vanes and between them and the surface to be illuminated. This prevents shadows being cast by the vanes in any position into which they may be turned and ensures an exceptionally good diffusion of light. The contiguous vanes, it will be noted from the way in which they are driven, turn in opposite directions. This prevents any shift in the position of the illuminated area and any change in

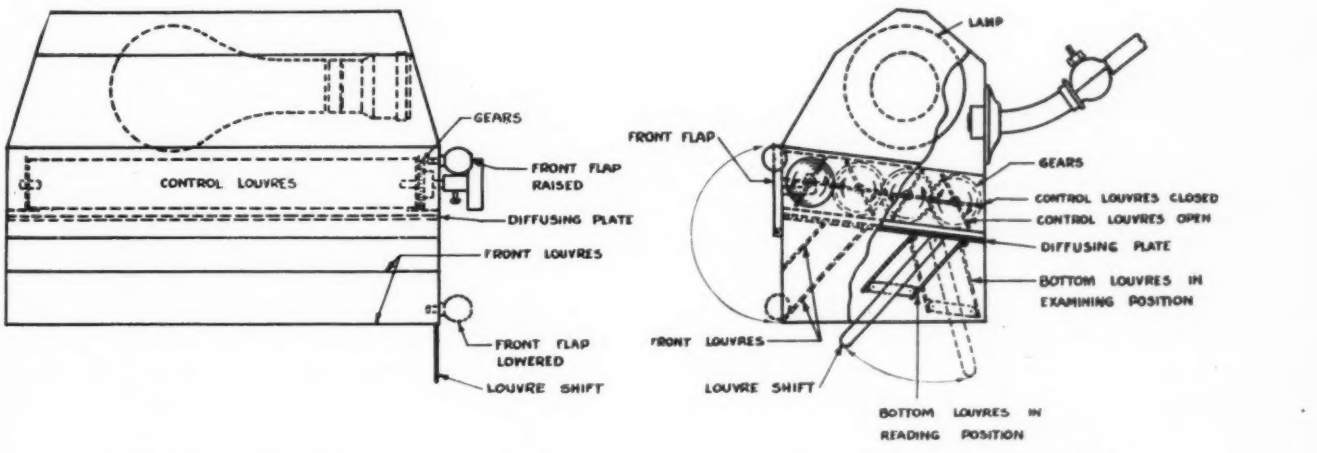


Fig. 2—A diagram showing front and side views of the combined reading and examining lamp.

its size or shape. When the vanes all move in the same direction, for example, as is the case in Venetian blinds, changes in all these respects take place. Such vanes as we have employed, in combination with a diffusion plate, provide a simple mechanical means of varying the intensity over any range of illumination that may be desired and can be used with a 1,000 as well as with a 25-watt lamp.

A bed lamp provided with this means for varying intensity is shown at the right of Fig. 1 and in Fig. 2. This type of unit is to be used both as a reading and as an examining lamp. It consists of the second model described, to which is added the means for varying intensity. This combination model may thus be made to serve all the purposes noted at the beginning of the paper. That is, with the flap over the front louvers turned up and the intensity control open, the unit gives its best lighting effects for reading and is the type best suited for use in homes and private rooms in hospitals; with the flap turned down and the intensity control open, it serves an excellent purpose as a ward light, and with the flap turned down and the bottom vanes turned into the vertical plane, it may be used as an examining lamp in which case the light control is used to vary the intensity of light on the patient's face from zero to any desired intensity through a wide range.

Patient Not Disturbed by Night Examination

To make an examination of the patient's face during the night, the unit is adjusted in position above the patient's head, the flap is turned down to close the front louvers, the bottom vanes are rotated into the vertical position and the intensity control is set at zero. At any time, then, one may turn on the light from a switch in the hall or in some other suitable place, go to the side of the bed and, beginning at zero, turn the knob which rotates the vanes until the desired intensity is obtained. When the unit is used in this way the chance of disturbing the patient should be reduced to a minimum.

In addition to the preceding units, there is need for a smaller, more conveniently portable, examining lamp which could be easily taken from bed to bed. To meet this need, we have constructed a unit that can be clamped on the head of the bed or supported in some other suitable way in cases where clamping to the bed is not permissible or desirable. This unit is 8 inches long, 5½ inches high and 5 inches deep. Since it is not intended for use as a reading lamp, neither bottom nor front louvers are provided. The rotating vanes for the variation of intensity are supplied, however, and the glass for the correction of the color of the light.

In this unit provisions are made so that this glass can be easily changed. That is, in ordinary examination of the face for the coloration of the skin or in cases which produce mottling or discoloration of the skin, the full correction for color should be used and the higher intensities of light. However, when the important factor is not to disturb the patient, as in examination of the color of the lips, the whites of the eyes and the skin in comatose or near comatose conditions, another commercial glass matched to a lower temperature color can well be used in connection with a minimum amount of light. Both this and the flashed opal glass mentioned should be double etched to give adequate diffusion of the light.

All Requirements Believed Satisfied

In these four units we believe we have conveniently and effectively satisfied the needs in a hospital bed lamp as defined at the beginning of this paper. The lighting effects from the first unit described are almost unbelievably good to those who have had experience with the usual type of bed lamp. It should be a source of great help and comfort to the patient who is able to read but must lie in bed. To those in health who are accustomed to reading in bed, it transforms a somewhat serious ocular vice into a comparatively harmless indulgence.

The second and third units described add to the features of the first the essentials of a ward light and an examining lamp with an effective intensity control in continuous change from zero to full over a wide range and with or without color correction.

The fourth unit is designed as an examining lamp alone, an important feature of which is ease and convenience of change from bed to bed. It is smaller and lighter than the other two and can be clamped to the head of the bed when desired. It is provided with the intensity control noted above and with either full or partial correction to daylight color.

Since this unit is not intended for reading and since the purpose of the examination requires that the light be received full on the patient's face, the glare protecting louvers across the bottom are omitted. In this connection, however, the eyes of the patient are safeguarded against undue glare by the highly absorbing daylight glass and by the intensity control which permits of short exposures and a suitable gradation of intensity of light.

In a later paper will be described a small glareless lamp that can be detached from its wall support and carried from the head to the foot of the bed for purposes of examination. This lamp is provided with a means of taking up the slack in the lampcord which is free from the objections that may be offered to the usual reeling devices.

Do the Newspapers Like You?

By PAUL E. FAUST
Trustee, Evanston Hospital, Evanston, Ill.

BECAUSE favorable newspaper publicity is one of the fundamental needs of a hospital in public relations work, and because of my interest in this whole subject as a hospital trustee and an advertising man, I recently interviewed a number of Chicago reporters on how hospitals rank as news sources.

To get the picture of the job of a reporter on the City Press, the principal local reporting agency for several classes of news in Chicago, it must be realized that that organization is on the job twenty-four hours a day. Each reporter covers a wide territory and while he leaves his office and goes out on location on many important cases, nevertheless a great deal of his detailed news gathering is done by telephone. At night the reporter is under great pressure because for a few early morning hours one City Press man is covering the entire county so far as the police, coroner's office and hospitals are concerned. One or two men from the newspapers may be doing a similar job.

Other hours in the day there are, of course, more men at work. But if we think of these one, two or three night men, we shall realize that if a news source does not cooperate, it complicates their task tremendously because the reporters have to go back and pick up some other source. Each item is actually a matter of minutes because of the pressure of time and the multitude of news items.

The Reporter Has to Get the News

Particularly important is the fact that if a hospital withholds data about deaths or accidents, the reporter is forced many times into the uncomfortable position of having to get his information from a harassed or grief-stricken family. The reporter has to get the news. He has no alternative. His managing editor gives him an assignment and nothing less than a complete statement of conditions and facts will suffice.

We see from this why it is important that each source of news be cooperative in its attitude, be able to give out essential facts, do it promptly, accommodatingly and accurately, day or night.

Hospitals are regarded by newspapers and press bureaus as one of the basic sources of news. But the manner in which hospitals view the news gathering organizations varies enormously.

From the standpoint of city editors and all the news gathering organizations, there are six hospitals in Chicago and Cook County that are considered most accommodating. Several hospitals are listed as hard. Reporters almost never go near them. They avoid them on every possible occasion.

In a recent case of suicide, in which the patient was brought to the hospital, the superintendent left instructions at the phone desk to allow reporters to get all details from the nurse on the case.

Recently during the illness of a local character of front page importance, the reporters had to wait during his last hours. This institution served the reporters from four city newspapers with their meals and set aside a phone room for their use.

Private Direct Wire to Police Exchange

At one Catholic hospital in Chicago there is a private direct wire to the police telephone exchange which reporters are allowed to use. When any phone call comes to this hospital, those in attendance give the information completely or else secure it at once and have it available on the next call; or they will telephone the data to the City Press.

Two other hospitals in Chicago are listed by reporters as cooperative. When necessary they put reporters' calls through to the receiving room where data are supplied either by the attendant or the police officer who may be on the case.

Reporters have their own gruesome humor. Recently, in the case of one hospital, they learned through the coroner's office that a man had died. The hospital in question had not been generous in its information, so the reporter called up the floor superintendent to ask how the man was getting along. The floor superintendent stated, "He is getting along as well as can be expected." The reporter then laid aside his humor and asked candidly when the man died, to which the floor superintendent replied that the reporter would have to get the information from police or coroner.

The net of all this is that hospitals are definitely classified by all the city editors and by the news gathering organizations according to the degree of their day and night cooperation. We may say frankly that the newspapers avoid mentioning the difficult hospitals as much as possible and that they freely mention the accommodating ones.

Editorials

Welcome A. C. H. A.

THE American College of Hospital Administrators held its first convocation in Philadelphia on September 23. That the aims and principles of this newcomer in the institutional field strongly appeal to executives generally was proved by the large number of participants at the annual banquet and by the generous proportions of the class of initiates.

To improve hospitalization by enlarging the training of institutional superintendents is a splendid endeavor. To create and maintain a high level of hospital ethics is equally laudatory. Such an organization need in no way compete with existing groups that are endeavoring to improve the care of the sick. It should only supplement such activities. The MODERN HOSPITAL, believing that unlimited possibilities for service are inherent in this organization, welcomes it to the institutional field.

The Grading Committee Reports

THE Committee on the Grading of Nursing Schools has issued its final report and disbanded without, apparently, having performed the function implied in its name. There has been no published "grading" of the schools. While this may be a disappointment to some persons interested in nursing education, more thoughtful students will doubtless praise the committee for concentrating attention on the fundamentals which have a permanent value.

Undoubtedly the work and recommendations of the committee will be extensively debated in hospital and nursing circles. The committee has definitely condemned nursing schools that in its opinion do not produce competent nurses. It lists eighteen "conditions not to be tolerated" in any school of nursing. It has set the professional school of nursing of university grade as the objective and has uncompromisingly stated that the education of nurses should not be considered as merely one aspect of hospital work and the school merely as one department of the hospital.

The question of nursing education is loaded with large financial stakes. This means that hospital trustees and administrators must be more than ordinarily careful to keep their thinking on the subject straightforward and sincere. They are charged with the responsibility of providing an essential public service often with inadequate means to finance it. Hence the pressure on hospitals to exploit the nursing situation is frequently very great and is often actuated by high motives.

In this confused and conflicting situation, it behooves every hospital administrator who has a nursing school under his direction to refrain from adding to the confusion by failure to understand correctly the recommendations of the grading committee. The least that can be expected is that each such superintendent will read the final report of the committee carefully and whether approving or disapproving will quote it accurately.

Weather Making

WHEN radio was enjoying its early popularity, the hospital patient demanded facilities so that he could listen to his favorite program. Today as a result of that demand most hospitals provide radio service to their patients in some form.

Theatrical and commercial use of weather making equipment now promises to create an irresistible demand for air conditioning in hospitals. The patient who can afford to do so may now rent an air conditioning apparatus that will ensure comfort during distressing postoperative days. But the public will not long be satisfied with this arrangement. The day is not far distant when operating rooms, private suites and wards will be air conditioned.

The hospital should not allow itself to be placed in the position of being coerced into practical application of this modern, humane development. The first institution that can guarantee scientific safety coupled with greater physical comfort will enjoy for a time at least the distinctive favor of a discriminating public.

Should the Intern Operate?

THE average intern mistakenly believes that the hospital service which gives him the most opportunity for solo operating is most to be desired. The newcomer in medicine yearns to cut and sew. He often possesses more daring and self-assurance than appreciation of his own shortcomings. He blithely undertakes the exploration of the human abdomen confident that he will be able to remedy whatever conditions are there encountered.

The hospital that countenances this endangering of human life is neither fair to the patient nor to

the intern. Many state boards of medical education are definitely committed to the decision that interns shall be permitted to perform only the most minor surgery even under supervision. Some hospitals include only dispensary and accident surgery in their intern schedules, assigning operating room experience to residents who are definitely specializing in surgery.

There are good reasons to substantiate this practice. A young and rash intern, having successfully performed a few major operations, becomes convinced not only of his own skill, but also of the simplicity of surgery generally. Leaving the hospital, he undertakes to render surgical treatment for which he has had the most meager training. He is deluded into a false security by the touch of the scalpel. To his clientele he is a surgeon because he so affirms. There is none to dispute him except perchance his colleagues, and their lips are sealed by a code of ethics that is in this instance harmful.

The responsibility for crimes of scientific omission and commission that can be charged against the inadequately trained physician who undertakes the performance of major surgery should in a measure at least be laid at the door of the hospital. Ignorance and credulity on the part of the public play no small part.

New Yearbook Built to Serve the Busy Administrator

THE thirteenth edition of The HOSPITAL YEARBOOK is now off the press and will be mailed as rapidly as the size of the task will permit. Before the middle of the month it should be in the hands of all subscribers.

This edition surpasses all previous editions in scope and quality of contents, simplicity of arrangements and practicability for the busy hospital administrator and his department heads. More than ever before the book has been built so as to justify its subtitle, "The Hospital Reference Book."

To simplify the use of the book all editorial material has been segregated into one compact section of 200 pages in the front of the book. Here may be found authoritative check lists for hospital planning and modernization, check lists on hospital equipment and supplies, a carefully prepared section on the organization of the hospital, check lists on noise control and accident prevention, articles in check list form on new trends in hospital administration, a comprehensive outline of financial practice, and sections on hospital housekeeping, laundry, and food service. A comprehensive directory of organizations in the health field and a glossary of hospital terms follow. The last two sections of the book give statistics on the hospital field and general reference information of value to all hospital workers.

The second half of the book contains the classified directory section. The index to this section contains more than 5,000 references that quickly tell the superintendent and the buyer where they may obtain any products needed for the institution. This section has been carefully revised and insofar as possible needless duplications are eliminated. It is the only complete and authoritative directory of its kind in existence.

Compulsory *Versus* Voluntary Philanthropy

IN THE welter of governmental abbreviations that have descended upon us one can find small hope for the future of the voluntary hospital in its present form of organization, with the philanthropic keystone built into its archway.

Amid the confusion of public works, due partly to administrative inefficiency, and partly to haste in forestalling economic collapse, someone should endeavor to formulate a master code quickly translatable into terms that may be read by him who runs, as well as by him who has been elected. Between philanthropic funds which are dwindling rapidly and on which we depended, and funds from taxation that are increasing rapidly, but which do not seem to be available for us in our trouble, where do we stand?

Will government increase its subsidy to voluntary hospitals to ensure their survival and, if not, who will take up the burden? If government will increase its subsidies, on what conditions will this be done? Will government consent to be taxed without being represented on the board of trustees of the hospital? Under which system of management does the voluntary hospital thrive better—the one in which the trustee represents his own and his friends' philanthropy, or the one in which the government official represents the contribution of the taxpayer? If government will not come to the rescue what will become of the voluntary hospital at a time when philanthropy is becoming more and more difficult, while the income from patient sources cannot be maintained? How would the bankruptcy laws apply to the failure of the voluntary hospital as a business and how much good would a receivership do under the circumstances?

It takes good management to keep the operating

deficit down to a minimum but, since this deficit represents a balance between income and expenditure, certain increases must take place on the one hand, or decreases on the other, or both. In any case, there are limits to efficient management, especially where the public health is concerned. Yet, no one seems to have got far in the analysis of the problem beyond the academic discussion of the merits of state medicine, or the rights of the practitioner who seems to have discovered, in adversity, what every hospital man has known in his heart even in times of prosperity—that the practice of medicine is a business as well as a science, and that some 150,000 physicians in the United States make a living out of it.

Has the voluntary hospital been too modest throughout the years, doing good without taking much public credit for it, and must we now suffer because those who are in high office seem to be able to see every other social problem but ours and make provisions for it? Perhaps they should be reminded that the same man who pays taxes to the government pays an extra voluntary tax for philanthropy whenever he can. This thought might lead to interesting developments. The question now is, what can the voluntary hospital do about the existing situation, assuming that it has fully justified itself and is correct in maintaining its right to survive the economic revolution?

Shopping Around

NO ONE can merit censure for attempting to secure the maximum in quantity and quality for the money spent. Chain stores strenuously compete with one another for the housewife's patronage. The druggist's windows are ablaze with combination offers and with special sale inducements. The haberdasher vies with his fellows in offering raiment at the lowest prices.

The hospital is no stranger to these practices. When the housewife announces to the head of the family that their first-born must have his tonsils removed the search for the most advantageous arrangement begins. Much to the gratification of the parents it is found that Hospital A will undersell Hospital B for this service by several dollars. Now Hospital C, when consulted, announces that it offers a flat rate for tonsillectomies that is still lower. The surgeon, wishing to oblige his clientele, operates in the last named institution although its physical equipment and reputation are inferior to those of the other two.

How confusing to the public is such a situation! How undignified and petty is such destructive competition to hospitals generally! But shopping for tonsillectomy, maternity or surgical service will continue until hospitals sheathe their economic swords and become a part of a great community plan for the betterment of the people. The hospital council appears to be the means to bring about this situation. A false desire for a so-called institutional autonomy is the siren that is luring hospitals to their own destruction.

The Nurse Anesthetist

THE nurse anesthetist is not as popular with the members of the medical profession as she formerly was. She is listed among those who are classed as interlopers in the medical field. She is charged with serving as a means of lessening the doctor's income.

It is asserted that only those who are medically trained should administer anesthetics. Hospitals have been criticized for profiteering by employing a nurse anesthetist and collecting many times her salary in fees from surgical patients. Staff physicians urge that every anesthetic in the case of a private patient should be administered by a doctor for which he should charge a fee.

Such a plan can hardly be recommended. Few physicians enjoy administering an anesthetic and still fewer are really competent to do so. To the doctor an anesthesia is merely an incident — a means to an end — the latter being the fee. To a nurse, each anesthesia is an event of the greatest moment. No other matter — the operation, the onlookers, the rarity of the pathology discovered — is likely to prove diverting. If physicians were as attentive, as well trained and as constantly available there would exist no place for the nurse anesthetist.

But there is a legal aspect to this problem. It has been asserted that the administration of an anesthetic even under the supervision of a physician constitutes the practice of medicine. The superior court of the state of California recently ruled that the administration of an anesthetic under the direction of a physician, in the meaning of that state's statute, does not constitute the practice of medicine, but that this act is one rightly carried out by a nurse. Courts in other states have not ruled quite so positively on this matter.

Nevertheless, the competent nurse anesthetist is capable of rendering a splendid contribution to the hospital's surgical patients. Unless the physician is willing to specialize in this branch of endeavor, he should not covet her place at the operating table. Hence, unless the medical profession can and will provide this type of substitute the nurse no doubt will continue to serve the surgeon and patient.

Is the Free Patient a Liability?*

Existence of the medical need is of prime importance in deciding as to the admission of free patients. Urgency of the need and ability of the patient to pay may then be considered. The hospital that fails to scrutinize applicants for free care mishandles the funds entrusted to it by a generous community

THE free patient has been the rock that has often split the usually amicable relations existing between the public and the private hospital. The public is likely to contend that a certain percentage, the exact limits of which cannot be set, of the free load should be borne by the voluntary hospital. The voluntary hospital asserts that most, if not all, of the free service to the community should be rendered by the hospital supported by tax funds.

A mistaken and unfair attitude on the part of the voluntary hospital has long existed in regard to the free patient. He has been too often unjustly maligned. Hence, it is the purpose of this sketch to demonstrate that the patient who is unable to meet hospital expenses is not always a liability. The appeal of the free patient is one of the chief reasons why hospitals were originally organized and in these troublous times why they are able to exist.

There is a growing belief that in the future the voluntary hospital will receive only a minimum of persons for free care and that the majority of such patients will be treated by public institutions. Others of the same mind conclude that this state of affairs will be brought about by the more or less universal adoption of health insurance or some workable plan whereby hospitalization expense will be met by the employer on a group basis.

*Practical Administrative Problems Series.

From a practical standpoint, the free patient plays an important rôle in the conduct of the average hospital. It is difficult to give away fifty cents of every hospital dollar, and yet avoid the use of red ink. Nevertheless, it is a fallacious argument to contend that the hospital would encounter little financial difficulty if it were not for the necessities of its charity work. To withdraw all service for which the hospital does not receive direct recompense would plunge the hospital into the arena of every day business and, stripping from it all of its humanitarian appeal, would leave it cold, stark and heartless. The hospital's chief attraction to a contributing public lies not in the stateliness and beauty of its architecture or in the apparent need for physical equipment with which to carry on its work. The urge to contribute to the hospital's future is largely centered in the free patient. Large benefactions are not often made to a grocery business or to other lines of commercial endeavor. The humanitarian appeal of the free patient is the magnet that attracts dollars which, without its drawing potentialities, would be diverted elsewhere.

The free patient makes an unconscious contribution to the hospital. Inherent in pain and suffering is an abstract something that develops the best in the patient and in those around about him. Pain opens the pocketbooks of those who are in possession of both money and disease. The sick possessing money observe the poor experiencing disease. The wealthy do not hesitate to spend large sums when illness comes to them or their families, and they are often moved to give generously when they observe sickness in others.

Free Patients Affect Income

Recently in a study of a large group of institutions, it was discovered that from 15 to 20 per cent of each hospital's income was derived from endowments, 7 per cent from city or state funds, 8 per cent from community chests and 4 per cent from cash contributions. In the block of larger and more prosperous hospitals, ranging from 200 to 400 beds, 20 per cent of the total income was derived from interest received on endowment funds. In further support of the recent assertion that the public appeal of the free patient has in the past been

practically transposed into hospital income, in this group it was observed that but 55 to 60 per cent of the total hospital income was earned.

City, county or state aid, particularly the last, often serves as a deterrent to contributions from the wealthy. It is natural, knowing that a certain institution receives a large grant from a public agency, to infer that this hospital does not require funds from an individual source.

It is not fair, however, to conclude that the free patient pays indirectly 20 per cent of the hospital expense because there exist other reasons, such as family traditions or a religious urge, that prompt the endowment of private hospitals.

A Spiritual Asset

Not uncommonly the free load of the hospital constitutes from 50 to 60 per cent of the total service given. While a direct comparison of the percentage of hospital income derived from interest on endowments and the percentage of free service given cannot be made, yet the fact that from two to three times as great a proportion of free patients are treated as is represented by the percentage of income from benefactions suggests an interesting line of thought to the hospital administrator.

The free patient represents in a somewhat less concrete manner a spiritual asset to the hospital. Contact with the sick generates in the hospital personnel a tendency to forgetfulness of self. Recently attention was directed in these columns to the fact that throughout all the period of labor unrest that has permeated this and other countries during the last few years, one has yet to learn of mass refusal on the part of hospital employees to work. This can be explained in no other way than by the nature of the work in which these men and women have been employed. Surely the personalities of hospital workers were not at the beginning of a different texture than those of others employed in industry. The free patient, even if in no greater measure than those of other economic classes, contributes toward bringing about this attitude on the part of those who serve the sick.

No one can clearly define the term "free patient." If the hospital's obligation begins only when absolute pauperism exists, then the problem is not of a difficult nature. Other factors determine the existence of a rightful claim on the hospital's benefactions on the part of an individual. The size of the income, the nature and duration of the ailment, the position of the sick man in the family circle, represent important factors that deserve the most careful inspection. All these and many others must be considered before the answer to the question "Can you pay?" is decided.

One should endeavor to discover an answer, for example, to the question as to how able is "able to pay." Unfortunately, no adequate yardstick exists, and the answer can be found only after the exercise of careful judgment, all available data being duly weighed. Let us glance for a moment at each of these considerations before attempting to arrive at a just solution of the problem. For example, a $20 a week income does not immediately place a patient outside the free class. If dependents in a family are of sufficient number to require the expenditure of this sum merely to maintain in them life itself, it would be a harsh justice that would dictate that one of its members becoming ill should be required to pay the hospital a major proportion of this sum. Often it is the expense of a family circle rather than its income that the credit worker must consider before ruling on the patient's ability to pay.

The nature and the duration of the ailment are vital factors to be considered in searching for an answer to this question. A prolonged chronic illness may so exhaust family reserves that there arrives a time when the hospital's aid can justly be sought. In some instances an acute episode in a chronic ailment demands immediate hospital admission. In others, while life may not be threatened, medical or surgical aid is required to relieve suffering or disability so that earning power may be more quickly restored. The nature of the ailment as it affects those not yet attacked by disease certainly has a bearing on the problem. Every physician can readily recall instances in which the early removal of a patient suffering with open tuberculosis might have prevented the infection of others and served to ward off a complicated individual and community problem. Hence, there enters into the situation not only an economic angle but also an important public health aspect. A wage earner suffering the disability wrought by a large inguinal hernia presents a greater need for quick rehabilitation than one affected with some other types of disease.

PERCENTAGE OF FREE, PART-PAY AND FULL-PAY WARD PATIENTS TREATED DURING YEAR BY 300-BED HOSPITAL

	Free	*Part-Pay*	*Full-Pay*
July, 1933	31	16	53
August	37	19	44
September	38	12	50
October	30	17	53
November	41	17	42
December	40	20	40
January, 1934	51	14	35
February	58	12	30
March	49	16	35
April	31	11	58
May	26	10	64
June	25	8	67

The troubled hospital executive who, while endeavoring to be fair, encounters spurious factors in the requests for free service is justifiably disgusted. For example, occasionally one observes in the case of a hospital receiving public aid a request by a lawmaker for the free admission of a patient who patently should occupy a private room. Again a shortsighted member of the hospital board may request hospital service for one able to pay, or a person of local religious or social importance may beg admission for a patient who under other circumstances would expect to reimburse the hospital for care. Such demands by persons influential by reason of community or political position represent merely a settlement of a personal debt, a quid pro quo for past favors received by the individual. One needs but mention, so well known is this abuse, the great number of patients who having but little claim on a gullible federal or state body are nevertheless unjustly given free care in government hospitals.

Experience of One 300-Bed Institution

The experience during a twelve-month period of one voluntary general hospital of approximately 300 beds in its effort to classify economically those seeking medical aid is given in the accompanying table. The table illustrates the percentage of free, part-pay and full-pay ward patients treated in the hospital, which admits approximately 8,000 ward patients a year.

It will be noted that the totally free patients vary during the several months of the year from a low of 25 per cent to a high of 58 per cent. No proper explanation can be given of this great difference unless it was due in the first instance to the exercise of better case work. On the other hand, it will be seen that there was also a variance of from 8 to 19 per cent in the part-pay group and of from 30 to 67 per cent in the full-pay class. A diminishing percentage of totally free work as the year progresses will be noted in this table. This fact can be ascribed to an improvement in general business conditions as well as a more careful scrutiny of applicants for the free list.

One of the most valuable lessons the public has learned during the past months of readjustment is that the hospital is not guilty of heartlessness when it requests payment on the part of ward patients for medical care. In this table there were included in the part-pay group all those persons who were unable to meet the full ward rate during their complete hospital stay. Indeed in some instances this group includes patients who really contributed but a few cents a day when a week's board was averaged throughout their total hospital stay.

Within the full-pay ward group were found many persons who were accustomed in the past to occupy semiprivate or private rooms and the part-pay group contained a lesser number who in other days would expect to meet all hospital expense for their care in a ward bed.

As an added explanation of a diminishing free and a rising full-pay percentage it may be said that while no unfair harshness was exercised in the study of an individual's ability to meet the hospital's expense before he was admitted, frequently what at first appeared to be a free case would later be classified in the part-pay or full-pay group. As credit work improves in quality the free percentage frequently drops, no hardship being worked on the individual patient by this process. One fact, then, appears to be outstanding in the study of these percentages. High free percentages depict not only a generally low economic status of a community but often also slipshod business methods on the part of the institution.

In the average conduct of the credit worker's office no facilities are provided for judging the existence of a medical emergency. Surely the admission of a chronic hernia is less urgent than that of a ruptured gastric ulcer, the latter being accepted without question as to payment for care and the former being justly somewhat delayed. No credit work can be efficient without medical cooperation, and the assurance of the family physician as to the urgency of the ailment or the economic condition of the patient is not always sufficient to the needs of the hospital. The justice of this statement is repeatedly verified by the admitting officer who learns by telephone that the diagnosis of the applicant is bronchopneumonia, later to discover that the most definite indication for the admission of the patient is that the remaining adult members of the family, tiring of caring for the patient, desire a vacation. The physician is performing a service to the family at the expense of the hospital.

Admitting Free Patients

When a request for the admission of a free patient is made, unless an emergency exists, it is better to ask some member of the family to visit the hospital to complete the arrangements. To require a note from a priest, a minister or a physician certifying to the existence of an economic need is most inefficient. Telephone requests, except in case of an emergency, should not be honored. It seems unjust for a patient to be given free admission to a certain hospital simply because he prefers this to another institution. Staff members should be given preference in the admission of free patients, all other things being equal.

How Tactful Librarians Get Case Histories Approved

By ANNA SCHULZE
Record Librarian, Pennsylvania Hospital, Philadelphia

ONE of the minor problems in almost every hospital is that of getting histories approved by chiefs of the various services. Let us assume that the records to be approved have been completed by the intern and are awaiting the signature of the chief. The rule allows a chief of service to appoint one of his assistants to perform this duty. In any case a doctor whose duty it is to approve records should come to the record room at least once a week for this purpose.

This is not always done, and here is where the record librarian must begin to use tact. To be really tactful, she must first understand the doctor's problems.

The chief in question has probably resolved many times not to allow records to accumulate, knowing that the task only becomes heavier. But each day is so crowded with rounds, clinics, teaching, consultations and office practice that a whole week slips by without his having thought of records—perhaps even a second week—and fifty or sixty records have accumulated.

Being Helpful in Little Ways

The librarian must keep in mind the difficulties of the doctor's job. When she reminds him of his shortcomings, she should do it gently, and when he does come in, she should be helpful. If he does not have time to do all the records at once, the librarian should sort them so that he can do the oldest ones first, leaving the more recent ones for the next day. The doctor may want a little help about the nomenclature, or he may be grateful if the librarian merely sits beside him and blots his work as he writes. These are small things and it may seem ridiculous to spend time on them when there is more important work to be done. But the librarian should welcome every opportunity to demonstrate her willingness to help, for ultimate success in this as in any other line of work depends on the amount of cooperation existing between her and her associates.

Some doctors spend a great deal of time in the wards and are therefore near the record room, while others must of necessity give considerable time to dispensary work. It so happens that the dispensary and record room at Pennsylvania Hospital are separated by a whole city block. When such a situation exists the librarian should tell the chief that if it is possible for him to stop in the record room, she will gladly send the records to the clinic, or to any other place he may designate, for him to sign. He will probably tell her what day to send them and in most cases her records will be signed and returned the same day. The doctor will appreciate the librarian's helpfulness and he will be ready another time to respond similarly.

The librarian must know the people with whom she works. If she has five different doctors whose duties include the signing of records, she will probably need five different methods of approach. She should be guided by the doctor's reactions. The serious, almost pompous doctor cannot be teased into doing his work. He is more likely to respond to a dignified approach and a respectful manner.

Posting the Weekly List

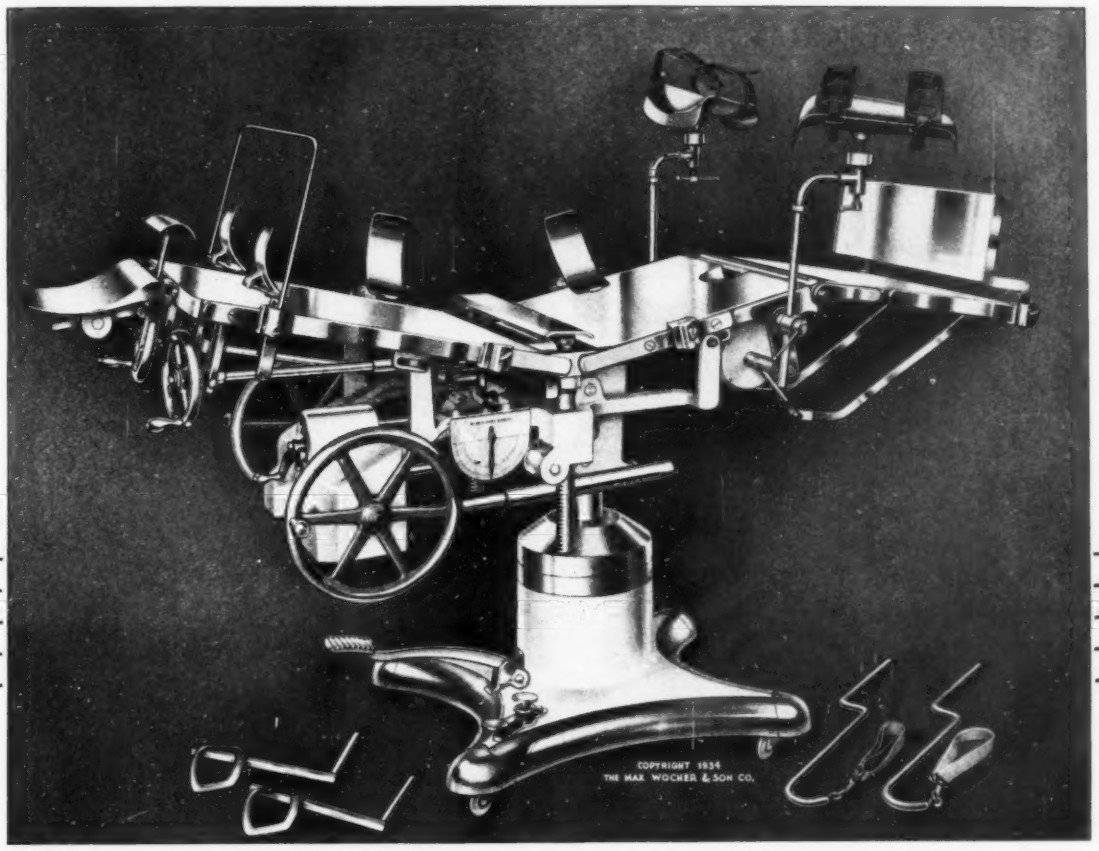
I'm sure all librarians have an "Alibi Ike" who in two minutes can think up a dozen reasons why he should not sign records today. Dignity would be entirely wasted on him, but by keeping after him, without nagging, of course, the proper results can be had. Now and then a little gentle scolding helps, but the librarian who allows herself to become angry is apt to make a bad matter worse.

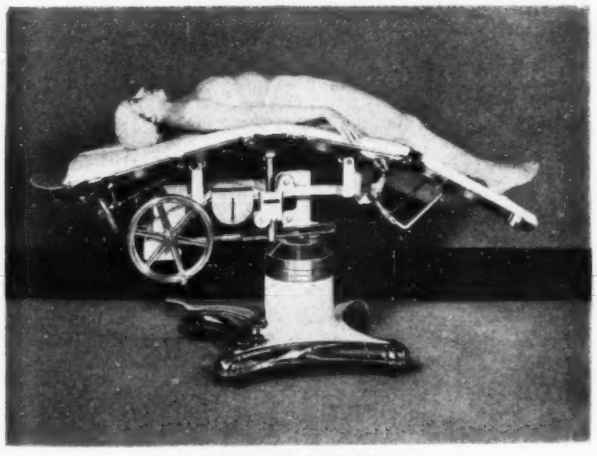
Just a word about the weekly list. This is posted in several conspicuous places in the hospital and shows the number of histories unapproved on each service, with the names of the chiefs responsible, arranged in alphabetical order. No history is posted until a week after the patient's discharge. That gives the doctor a week's grace. The list indicates the number of histories unapproved over one week and those over two weeks.

In general, the librarian should encourage criticism of the system, the nomenclature, and anything in the record room, even though she has no control over the matter. She can pass criticism on to someone higher up—the record committee or the superintendent. In any case she should show her interest and listen with respect.

She should try not to show her personal feelings. There may be one or two members of the staff whom she does not particularly like, but she must remember that the hospital is paying her to do certain work and she must learn to be impartial in her dealings with her co-workers, whether of the professional or lay group.[1]

[1]Read before the Philadelphia Record Librarians Association.





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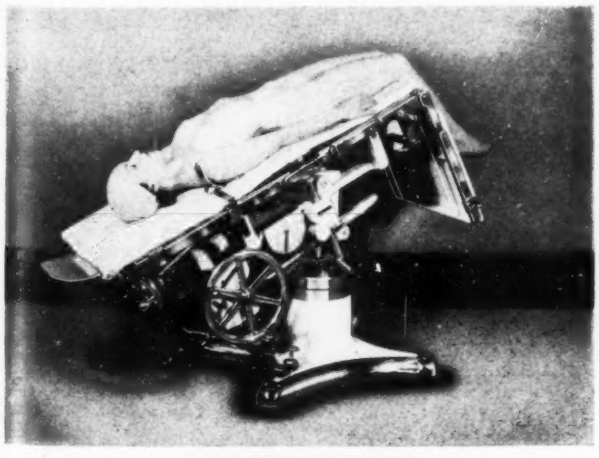

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Wherefore the A. C. H. A.?

By ROBERT E. NEFF
Administrator, University of Iowa Hospitals, Iowa City

THE hospital field and its allied agencies long ago recognized the need for efficient administrators, realizing that progress in promoting hospital administration as a science depended largely upon experienced and capable executives.

The American Hospital Association has been devoting its services to the advancement of standards in the field of hospital administration. The American College of Surgeons has also concerned itself in the matter of promoting better standards in hospital operation. Enterprising hospital executives have been found to favor and support every effort tending to enhance in the public mind a recognition and respect for the hospital administrator.

Wanted: A Recognized Educational Agency

What is the situation in the hospital field with respect to management? Are all hospitals directed by professionally trained and experienced executives?

They are not. Most of our nationally recognized administrators have attained their positions through experience, having come up through the ranks from subordinate positions in the hospital organization, while others with broad vision of service and educational background have achieved their positions by serious, persistent, capable and energetic application to their jobs. There has been no recognized educational agency, as is available in other professions, through which a man could prepare himself for the job. There have been available in the field of hospital administration comparatively few persons trained in a professional sense.

Rather indefinite progress has been made in the training of hospital executives or in preparation for administrative work. As a result, many are entering the field as superintendents with little or no knowledge of or fitness for this important work. Some are succeeding, some are failing, and many are blundering during the initial years. The time has come when there should be some distinction between the tried, well trained, successful administrator and the new, inexperienced, improperly trained and unfit administrator. How can this public recognition be brought about?

The American College of Hospital Administrators gives promise of making its influence an impelling factor in the elevation of standards of hospital administration and the establishment of criteria by which the competency of hospital administrators may be judged and recognized. It is destined to become an important factor in speeding the day of better qualified executives. Notable achievements in the hospital field deserve commendation and recognition, a reward for which will stimulate superior action and praiseworthy conduct. Formal acknowledgment and approbation of accomplishment conferred with dignity by an organization will most certainly bring self-respect and pride to the recipient.

The American College of Hospital Administrators is now ready to assume a position of importance among organizations in the hospital field. With its expert and superior talent it is in a position to make contributions to efforts toward economic adjustment. The field today offers almost boundless opportunity for research and service. The return of prosperity will demand logical and sound action based upon facts and sound principles.

What can be done to work out an equitable distribution of hospital beds in the United States? How can the waste and uselessness of surplus hospital facilities in certain communities be avoided? What means can be employed to finance the care of charity patients in community hospitals? To what extent can government subsidy be expected to support hospitals as community enterprises? These are examples of the many problems which must be the concern of national organizations.

Fellowship and Cooperation

No intention or design whatever has the American College of Hospital Administrators for assuming the functions, the powers or the rights of other organizations. The principle of fellowship and cooperation must prevail. It must work jointly with all interests for the promotion of hospital developments. It must be a part of the coordinated activity.

The strength of the organization will be determined by its policy, its management, and the extent to which it can usefully serve the hospital profession at large and also satisfy its members and clientele. Achievement based on these principles brings popular good will and confidence and places upon the organization a responsibility which those directing it feel most keenly. Capable management and good service naturally grow out of this sense of responsibility.[1]

[1]Extracts from the presidential address before the American College of Hospital Administrators, Philadelphia, Sept. 23, 1934.

Maintenance, Operation and Equipment

Conducted by JOHN C. DINSMORE *and* DR. R. C. BUERKI

Biological Photography as a Hospital Service

By THEODORE E. SCHWARZ, M.D.
Assistant Superintendent, Alameda County Hospital, Oakland, Calif.

PICTURES speak a universal language. Today we receive literature pictorially, as well as news, history and fiction. Pictures have come to be important in modern teaching methods and public schools are installing picture teaching methods. It has been demonstrated that human beings are visual-minded and anything that can be presented to the eye has far greater chance of being recorded, retained and recalled than has information received otherwise.

Newest of Hospital Departments

To depend upon words for a description limits the vividness of the word picture to the writer's or speaker's skill in the use of words. The usual word description is garbled, tiresome and confusing. Imagine a Gray's Anatomy without illustrations! The modern, highly developed photographic film that is made sensitive to all the delicate shadings of color values, reproducing them in graduated degrees of whites and blacks, records a most accurate and candid description that no word picture can duplicate.

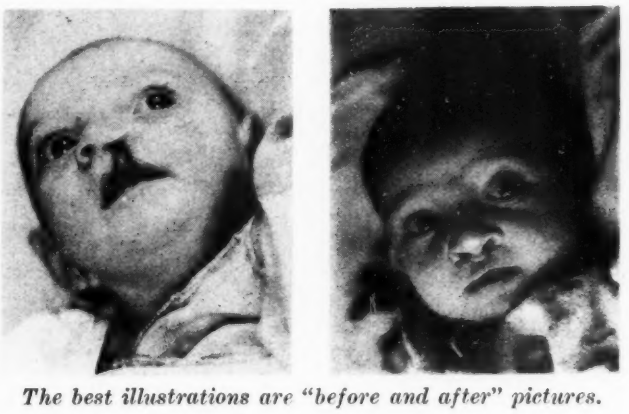
Biological photography is this accurate and candid recording of cases. The term "clinical photography" is frequently used and is a good one, but limited to pictures of cases. The term "biological photography" is broader and embraces all the various items constituting the description and results of disease, including gross pathology and the microscopic fields.

Biological photography is the most recent of all hospital departments and it is rapidly developing in usefulness and importance. Its object, primarily, is to keep photographic records of hospital cases—not all the cases, but those with external manifestations of disease or injury. From this primary function a surprising number of secondary functions have developed—functions that, so far as popularity and usefulness are concerned, far outshadow the primary reason for the department's existence.

When a hospital case is photographed, the first print from the negative is filed away in the patient's clinical record. A second print is put into the general hospital albums, which constitute illustrated pathologic files, and are classified by departments, such as medicine, surgery, pathology, orthopedics and cancer. These albums make splendid reference books for assembling cases for study. Thus are displayed illustrations of the different manifestations of the disease as well as examples of the various types.

May Be Used for Lantern Slides

From the same books certain cases are selected to be made into lantern slides. These slides are first shown at the regular meetings of the hospital staff as part of the program for the study of the cases in the hospital, interesting postmortem findings, pathologic specimens and operating room



The best illustrations are "before and after" pictures.

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Eastman Prepared Processing Powders

MAINTENANCE, OPERATION AND EQUIPMENT

A merry group from the pediatrics department illustrates the appeal to the public that can be made from hospital photography.

material. The enlarged picture is thrown on the screen, making a clear and clean display. Since the entire audience is viewing the same picture at the same time, the demonstrator is much assisted in his graphic portrayal of the manifestations of the disease. This is a definite improvement over the old method of passing smelly specimens to the audience for inspection or that of handing prints around so that while part of the listeners were looking at one set of prints, the speaker was four prints ahead of them.

So numerous are the interesting cases for illustration that the entire program of a hospital staff meeting is frequently presented pictorially. The large number of illustrations used in medical meetings today indicates the popularity of biological photography and proves its universal acceptance as a modern scientific teaching adjunct. Truly, one picture is equal to a thousand words.

Why All Doctors Attend Staff Meetings

At the Alameda County Hospital the attendance at regular staff meetings is reported to be 100 per cent. This is attributed solely to the attractions offered by the pictorial display of cases. As many as twenty-five cases are presented in one evening, each case clearly pictured and accompanied by a five-minute talk from the physician who had charge of the case. A longer speech is not necessary; the pictures tell the story. Pictures have been called visual shorthand, as the eye instantly grasps a hundred details. Relieved of the necessity of making a word description, the speaker concentrates his remarks on the fundamental and vital points of his case and thus is presented a snappy program that is a joy to attend.

The used lantern slides, that is, the slides presented at staff programs, are then filed away in the hospital's rapidly growing library of medical illustrations where they are available to physicians who may be called upon to deliver medical lectures. Neighboring county medical societies enjoy such help to their programs and the talks are made doubly acceptable because of the interesting pictures selected.

Use in Giving Talks to Laity

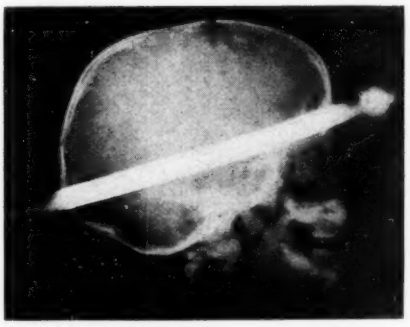
Another surprising secondary function of these lantern slides is their use in medical talks to the laity. Luncheon and service clubs require many speakers and present a splendid opportunity for a physician to deliver a medical message to the public. The lantern slides convey this authentic medical information that could be delivered in no other way. By these means a physician is able to deliver a laudable address, while without the aid of the pictures he would be considered a miserable speaker.

Projects so difficult as the dissemination of information to the public on cancer could be accomplished in no other way. Hundreds of such talks have recently been made to win the cooperation of the public in the splendid work sponsored by the American College of Surgeons. Cancer clinics have made available a wide variety of cases show-

MAINTENANCE, OPERATION AND EQUIPMENT

ing the stages of improvement to the complete cure, thus bringing a message of hope and encouraging the early diagnosis of this dreaded affliction. Each hospital in the country could do its part in this humanitarian work by making available the services of its biological photographic department in educating the public.

Lectures to high school students on traffic regulations and highway safety can be made effective by showing cases of human wreckage as they appear at the hospital as the result of someone's carelessness and disregard for the rules of highway safety. This is a work that should appeal to all physicians and every city in the nation would welcome this service in assisting to make its streets safer for the pedestrian as well as for the motorist. The photographic department can assist the doctor in rendering this civic service.



An x-ray picture of a boy's head through which a bolt had been driven.

The many uses of lantern slides can best be illustrated by relating an incident. A member of the Alameda County Hospital staff assembled a series of pictures for a medical talk on "The Modern Treatment of Extensive Burns." The same slides were then used in connection with an address before the nurses' association on the subject of "The Nursing Problems in Cases of Extensive Burns." This physician next addressed a state convention of safety engineers, again using the same pictures, on "Extensive Burns as an Industrial Hazard." Each group received his talk with outspoken expressions of appreciation. Such experiences will convert any physician to the full acceptance of biological photography as an important and useful hospital department.

How can all this be accomplished? The first and most important axiom is that a physician must be at the head of the department, as no other person can recognize the medical story presented by the case. He must be a man who can obtain pleasure in assisting other physicians to make a speech and generously give of his collected illustrated material. The best illustrations are "before and after" pictures. Patients must be followed through their period of convalescence and even recalled from their homes after they can show completed cures. In recording a surgical operation photographically, pictures are taken of the completed stages of the operation. It naturally follows that only a physician would know what to photograph, and he must be photograph-conscious as well as medical-minded. He must be an enthusiastic camera addict with a highly developed news sense and knowledge of propaganda values, quick to grasp the story and resourceful in filling in the missing parts by diagrams and sketches. His completed story must then be freely given to the physician who had charge of the case so that he can make a public presentation of the material.

The hospital's pathologist is the logical man to be selected, first because all interesting pathologic material passes through his hands, and second because he is always present in the hospital to record photographically any interesting case that may develop on the wards or in the emergency department. The value of a biological photographic department will be in direct proportion to the standards of the medical man in charge of the department.

The necessary equipment for doing this work is simple and the expense of photographic material is so small that it can be absorbed by the x-ray department by adding the cost of the items to their photographic material account. No special solutions need be prepared as the negatives, as well as the lantern slide plates, can be developed in the x-ray developing tank. The detail work is tremen-

ALAMEDA COUNTY INSTITUTIONS

DECEMBER 1933

DEATHS:	
Surgical	21
Medical	56
Emergency	31
Stillborns	3
CAUSES FOR DEATH:	
Acute Pulmonary Disease	15
Cardio-Renal-Vascular Disease	26
Organic Diseases -- Surgical	11
Malignancies	10
Acute Infectious and Contagious Diseases	6
Fracture Skull	2
Prematurity	3
Traumatic and Shock	2
Other causes	3
INFECTIONS:	
Surgical	1
Obstetrical	1
Percentage of Autopsies to Hospital Deaths	48 7/10%

Photography has its uses for monthly case summaries.

dous and requires much time. Usually a clerk and the x-ray technician can take over much of the detail work. The chairman of the program committee is always a great help in arranging for the best display and best presentation of the cases.

Biological photography is definitely established as a hospital activity. Its service is highly appreciated by the members of the hospital staff and it makes a definite contribution to the staff's scientific interest in hospital work. It definitely spreads this scientific interest through the rank and file of the medical profession by presenting many interesting programs to medical societies. It elevates the position of the hospital as a scientific institution that dispenses to the community medical knowledge as well as medical care. It is the means whereby much humanitarian work can be done and civic service rendered. These are the causes for the existence of biological photography and the bases of its plea for recognition.

A Check on the Efficiency of Autoclave Sterilization

PROPER technique is essential in all hospital sterilization, particularly in regard to dressings. Because incomplete sterilization could easily result in the death of the patient, sterilization in every well managed institution is carried on in a highly conservative manner with due regard to pressures and temperatures.

While oversterilization does not endanger the patient in any way, it does increase the cost per patient day since too much heat for too long a period materially reduces the life of all fabrics sterilized. Oversterilization also consumes an extra amount of steam and makes the labor cost higher than necessary.

Because adequate research has proved that moist heat is the only desirable type for items commonly sterilized in autoclaves, live steam is generally used for sterilization. On the assumption that there is always a constant relationship between steam temperature and steam pressure, autoclaves have until recently been equipped with pressure gauges to indicate sterilization temperature.

Pressure Gauge May Give False Evidence

There is no doubt that a steam gauge indicating pressure also indicates the temperature as and when steam is being produced in that pressure. The major fallacy lies in the fact that some of the pressure registered in the gauges may not be due to steam. It may be due in part to air compressed under steam pressures.

For example, in an autoclave the steam may be admitted under twenty pounds' pressure. If the air is not removed from the autoclave the pressure gauge will indicate the true pressure of twenty pounds and a corresponding temperature of 255° F. While the temperature of the steam in the autoclave will be as indicated, the air that is trapped may actually be lower than body temperature. Consequently it is safe to conclude that the temperatures in an autoclave are as indicated only when there is no entrapped air.

Trap May Fail to Work

The practice of removing the air from an autoclave before sterilization has started by means of a vacuum produced either by a pump or by a steam operated jet is of many years' standing and is now declared unnecessary and wasteful of steam, time and labor. The research division of one large sterilizer equipment company has made an exhaustive study of this matter and has proved to its satisfaction that a vacuum does not aid sterilization if the air is properly removed by adequate trapping equipment. It is obvious that if the steam enters the autoclave at the top and discharges its water and air at the bottom, a temperature controlled trap that permits air and water but not high pressure steam to pass will eliminate all air. This much of the technique has already been established in most progressive hospitals; however, there is always the danger that any trap will occasionally fail to operate.

If complete reliance is placed upon the gauge indicating pressure and upon the assumption that the automatic trap is properly venting the air, the technique is still imperfect. The danger lies in the fact that if the trap should fail to work the pres-

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sure will build up within the autoclave, as it should, and the pressure gauge will indicate a false temperature because the autoclave contains air.

A simple method of checking the behavior of the trap and at the same time of procuring an accurate temperature record is to place in the return line a thermostatic bulb leading to the temperature recording gauge (to take the place of the pressure recording gauges). Since the temperature of the bulb cannot go any higher than the temperature of the exhaust material from the autoclave, the recording gauge will not indicate a temperature higher than that actually existing at the exit point of the autoclave. It is impossible for steam to reach the exhaust part of the autoclave until all the air has been eliminated. Consequently these readings may be taken with complete assurance that they are correct because they will indicate the minimum temperature existing in any part of the sterilizer.

One of the large sterilizer equipment companies placed a thermocouple in the center of a drum of tightly packed dressings for experimental purposes. By means of this thermocouple the technique described has been checked and rechecked and found to be safe and much more economical than the old procedure.

The saving would show itself in many directions. First, complete sterilization is assured because if the traps ever become plugged the recording temperature gauges will at once reveal the fact. Second, a definite saving in steam, perhaps from 30 to 50 per cent, is possible because most sterilizers are operated much longer than proper sterilization requires. Third, the life of the textiles is lengthened because exposure to high steam temperatures tends to shorten their life. Fourth, the labor factor is improved for sterilizing time is shortened.

The changes necessary to bring sterilizing equipment up to this new standard are (1) installation of a somewhat superior type of vent, (2) replacement of the pressure recording gauges by temperature recording gauges and (3) installation of the thermostatic bulb in the discharge line as part of the temperature recording equipment at modest cost.

Hospitals that utilize the new technique will secure definite increase in security, also desirable should there ever arise a medicolegal problem involving the question of sterilization of dressings.

Bottle Filler Devised by Hospital

The filling of large numbers of bottles with heavy liquids has been a problem in every hospital pharmacy. A few manufacturing concerns have recognized this difficulty and have put on the market bottle filling devices. For the most part the operation of such equipment has not been satisfactory and its price has been prohibitive to many hospitals.

The University of Chicago Clinics have developed a bottle filler which, although by no means perfect, works well and has proved to have many advantages. The total cost was only $6, and the device has brought about considerable saving in time and material.

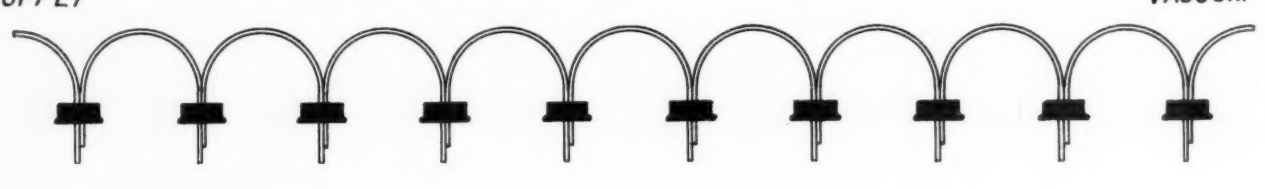
Two lines of hollow copper tubing were easily bent into the shapes shown in the illustration. Holes for the tubing were punched into ordinary bottle screw caps and the tubing was soldered to the cap. The tube projecting through the cap on the vacuum side of the line was made shorter than the other tube to ensure a uniform and exact level of filling.

Bottles are screwed into the caps and a vacuum is produced at the vacuum end of the line. At the supply end of the line a hollow glass rod and a piece of rubber tubing are used as connections, the glass rod being inserted into the liquid in the original container. Liquid then replaces the air drawn from the bottles by the vacuum.

The vacuum can be supplied by an ordinary water vacuum or by a small vacuum pump. Either works well, but the superior vacuum created by the pump speeds up the filling process.

The filling time of the bottles is such that when two such lines are in use one man is kept busy. While the bottles in one line are filling the man removes the full bottles from the other line, caps them and replaces them with empties. The bottles on the other line are now full and the supply and vacuum connections are removed and changed to the line of empties. This process continues and it is possible for one man to fill twenty pint bottles every three minutes.

The advantages of this equipment are: (1) low first cost, (2) greater speed in filling bottles, (3) a uniform quantity in every bottle and (4) prevention of waste in pouring.



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2. **Because of its low moisture content, Ry-Krisp absorbs five times its own weight in water. This, together with its 16 per cent of bran, makes Ry-Krisp a significant addition in the way of bulk.**
3. **Twelve per cent of Ry-Krisp's total carbohydrates are not digestible.**
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Dietetics and Institutional Food Service

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

Tips on Buying Canned Goods

By LOUISE Y. GILBERT
Director, Food Service, Evanston Hospital, Evanston, Ill.

A RATHER large proportion of the institutional food budget is spent for canned goods. The amount, of course, depends upon the seasons of the year and the geographical location of the institution. A fair estimate would be to say that from 15 to 20 per cent of food cost is for canned goods.

In localities where fresh fruits and vegetables are easily and cheaply obtained and where labor is not prohibitive, fewer canned foods are used. In the average institution these factors prevent the extensive use of fresh fruits and vegetables, however, and canned foods have to be substituted. The quality of foods put into cans is often better than that of fresh foods, especially during the winter months, and the food value is comparable.

Why the Task Is Complicated

The task of selecting canned foods is complicated by lack of uniformity in the pack of foods, variations in the size and quality within the can and incomplete information on labels of cans relative to contents. These conditions are being improved since the passage of the McNary Mapes Amendment to the Food Bill in 1930. The purpose of this bill is to discourage the canning of inferior merchandise by setting a definite standard of quality for each food canned and requiring the label on the can to state if the contents are below this standard.

Since canners do not like to have to label a food "substandard," they are improving the contents of the cans so that they will measure up to government specifications. This is tending generally to improve the pack. Since the lowest grade is improved, the better grades also must be improved. To date only a few food items have been standardized as this is a long, slow process. Of the vegetables, peas and tomatoes are being packed according to this standard; of the fruits, cherries, apricots, peaches and pears.

Among the many important factors to bear in mind when purchasing canned goods are geographical location of the cannery, varieties of vegetables or fruits canned, grades of foods, net weights in cans and price. Geographical location of the cannery should be considered because certain varieties and qualities of food are canned in certain regions. The buyer must be familiar with the chief producing areas from which come foods of best quality. Canneries will be found within these areas, which may be scattered throughout the country. The character of the food will vary, depending upon the region from which it comes.

The cost of any commodity should be considered only after all the other value determining factors have been weighed. This is especially true of canned goods for there is frequently a wide range of drained weights in the different grades, sometimes completely offsetting the difference in prices of the packs. On the other hand, the range of price may be based on the size of fruit or vegetable, or on the degree of syrup of a fruit. In many cases the less expensive may more nearly suit the purpose for which the food is to be used.

There are three generally accepted grades for canned goods which for vegetables are fancy, extra standard and standard. Generally speaking, fancy grade calls for the cream of the pack. Extra stand-

Since the different canners' packs lack uniformity, the canned goods buyer should formulate some working rules for purchasing in order to ensure uniform quality of institutional food. Mrs. Gilbert believes that contracting for canned goods is of the greatest assistance in hospital buying

ard is a good quality but slightly below fancy in tenderness, color and general appearance. The standard grade does not quite equal the extra standard but is wholesome and edible. Often there is a lighter pack per can also, so that in making a selection of this grade, the drained weight should be checked.

An important consideration in the selection of canned vegetables is variety. For example, the Early June or Alaska pea is a firm pea, not sweet but good for salads and sauces, and it stands well in a steam table without mushing. The sweet wrinkled pea is tender, sweet, full of flavor and quite delicious to use as a vegetable side dish but because of its texture it crushes easily and cannot stand rough handling. Therefore it should be purchased in the small No. 2 can rather than in the large No. 10 can.

Tomatoes are packed in several states. There is a distinct difference in the flavor of those canned in New York State, for instance, and those canned in western Indiana. Here again the buyer should use great care in the choice of large or small cans depending upon the desired appearance of the food when served. It is impossible to have whole tomatoes from large cans but for general cooking purposes it is more economical to buy in large cans.

Corn presents a different problem. Several varieties and styles are canned and the one best liked by the personnel should be selected. Corn takes a long processing at a high temperature and for this reason fancy quality is obtained only in No. 2 cans. In order to process sufficiently the center of a No. 10 can, considerable heat is required and this frequently scorches the outside portion and makes it tough. Corn in a No. 10 can may be used for escalloped dishes and soup but not for a side dish vegetable.

When Size Determines Price

The size of the vegetable canned often determines the grade of the item. Such foods as peas, string beans, lima beans and whole beets are considered better if they are small, while large tomatoes and asparagus are more fancy. For general institutional use it is not necessary to buy this quality and when there is a difference of price based on size primarily, the less expensive item usually will suffice.

Referring to canned fruits, the gradings adopted by the Canners' League of California governing the packing of California and Northwestern fruits are fancy, choice, standard and seconds. The fancy grade is of superlative quality, packed in extra heavy syrup. The choice grade is of fine quality packed in heavy syrup. The standard grade is of good quality packed in medium syrup. The second grade, when packed in light syrup, is designated as "second"; when packed in water, as "water pack," and when packed solid for bakers' use, as "pie." If the foods in this group are below standard quality, the food law requires the label to specify: "Below U. S. Standard."

Some canned fruits are known as heavy syrup fruits, others as light syrup fruits. The degree of syrup used depends upon the textures, acidity and flavor of the fruit. Fruits canned in heavy syrup are apricots, peaches, plums, berries, figs and fruit salad. The syrups used are fancy, 55°; choice, 40°; standard, 25°, and seconds, 10°.

No. 5—Doctor Salad

By Arnold Shircliffe*

Tomato
Cottage Cheese

Water Cress
Lettuce

ON A BED of lettuce, place a slice of ripe tomato. Cover the tomato with a mound of cottage cheese mixed with finely chopped water cress or chives. Place a rosette of water cress at the side. Serve with French dressing.

*Author of the Edgewater Beach Salad Book.

The so-called light syrup fruits include pears, Royal Anne cherries and grapes. The syrups used on these fruits are fancy, 40°; choice, 30°; standard, 20°, and seconds, 10°. The degree of syrup indicates the amount or percentage of sugar used in each 100 pounds. Thus a 55° syrup signifies that 55 pounds of sugar to 45 pounds of water were used.

The degree of syrup used on canned fruits and berries is not uniform throughout the country as some Eastern and Great Lakes packers use slightly different degrees than those adopted by the Canners' League of California. Also, it is well to bear in mind that the test when cut or the cut-out degree of syrup will not show up the same as when packed. The syrup will be thinner the longer the fruit stands in the cans, because of the absorption of sugar by the fruit and loss of water content. This will amount to 12 to 15 per cent so that a 40° syrup will show on cut-out only about 25 to 28°.

Use Determines Grade

As in the case of vegetables, general appearance, perfection, color, size and texture, as well as syrup, are determining factors in the price of fruit. The larger the fruit, except figs perhaps, the better the quality. Here again the buyer must consider the use of the fruit before deciding whether to buy a high or a low priced grade. If it is to be cut up to use for salads, fruit cups and gelatin desserts or as a breakfast fruit, a lighter syrup and a smaller size are preferable. For special salads, as Melba peach or whole pear, or for sauce when only one piece is required for a serving, the larger fruit should be chosen. Frequently it proves less expensive to use the larger fruit when fewer pieces are required per serving.

A factor that affects the price of apricots is the peeling. A peeled apricot costs more but it is so superior to the unpeeled one that it ought to be used exclusively so that in due time the canners would stop canning any other way.

Some canners pack good quality fruit without syrup for pie use while others pack overripe and green fruits, broken pieces and all other undesirable fruits under a "pie" label. It is therefore well to give due consideration to the purchase of this item in order to secure really good merchandise.

Salmon, another rather large canned goods item, offers several species and grades with wide variation in prices. The kinds that are richest in oil and of finest flavor and deep color command the highest prices. The Royal Chinook is considered the finest with Puget Sound sockeye and Alaska red sockeye next in line. Salmon is packed in tall No. 1 cans and in flat No. 1 cans, the latter costing more.

Many other foods are put up in cans, each of which needs certain special consideration in selection. Ripe olives, for instance, vary in size from "medium" with an average count of 113 to the pound, to "colossal" with an average of only 40 to the pound. The smaller mission and manzanilla varieties have a superior flavor and oil content, yield more servings to the can and are often a better purchase. Many prepared foods put up in cans must be selected especially by their flavor, as cream soups, sauerkraut, baked beans and tomato juice, and the best way to select them is on the taste basis.

Since the different canners' packs lack uniformity at the present time, the canned goods buyer should formulate some working rules for purchasing in order to ensure uniform quality of institutional food.

First it is necessary to become familiar with the leading brands or labels of the companies with which the institution deals. Most jobbers or wholesale houses have certain labels for each grade of merchandise they handle. Canneries, too, have their labels. For example, all fancy grades of food, whether fruit, vegetables, fish or meats, are sold under one label, which is a patented trade name of that house. Likewise, choice fruits and extra standard vegetables will be designated by a second label, and standard vegetables by still another. Some houses have other brands which do not run through an entire grade but in which they carry only certain foods.

What the Labels Mean

These labels indicate any quality, that is, better than the top label or below it. Frequently special purchases from canners are put under these labels and sold at reasonable prices. The merchandise usually does not measure up to the jobber's top label, but it is better than the next lower grade, and it is sold near the price of the lower grade. Such items should be inspected before purchasing. Sometimes goods are sold under the packer's label, usually because they fall below the quality of the jobber's better label. The price is consequently lower and the merchandise is often very good.

There is a difference of opinion among buyers as to whether it pays to make yearly contracts on the estimated future requirements of canned goods. Personally, I am in favor of the plan for the contract usually guarantees the buyer the lower price in case of a decline in the market and protects him if the market rises. Another important point in favor of the plan is the assurance of more uniformity of canned foods throughout the year. If purchases are made "spot" one order of tomatoes may be highly acid, requiring additional

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1. PRUNES NOW KNOWN TO CONTAIN AN ACTIVE LAXATIVE AGENT *in addition to* THE SMOOTH BULK THEY PROVIDE. No other fruit or food, including all those supplying roughage, is known to possess the principle present in California Prunes. This makes them doubly effective in stimulating intestinal action.

2. PRUNES DO NOT AFFECT THE ALKALINE RESERVE OF THE BLOOD. As much as 200 grams (18 prunes) in the usual diet does not significantly affect either CO_2 combining power of blood plasma or hydrogen ion concentration of the urine. The potential alkalinity of the ash of prunes is 24.4 (cc normal acid per 100 grams of prune flesh).

3. PRUNES CONTAIN IMPORTANT VITAMINS IN SIGNIFICANT QUANTITIES. California Prunes (as sold) are a good source of vitamin A (500 Sherman units per ounce of flesh); good source of vitamin B (22 Sherman units); and an excellent source of vitamin G (80 Sherman units).

4. PRUNES CONTAIN ESSENTIAL MINERALS. Considerable amounts of mineral elements are contained in California Prunes, including calcium, potassium, phosphorus, sodium, iron, magnesium, manganese, copper, chlorine and sulphur.

5. PRUNES AND THEIR RELATION TO HEMOGLOBIN AND RED-CELL RESTORATION. It has been determined (according to controlled animal study) that prunes are among the outstanding fruits highest in iron and copper content, and are acquiring increasing importance in the dietary because of these two valuable elements.

6. PRUNES HAVE HIGH ENERGY VALUE. California Prunes are an excellent source of quickly available food energy owing to their high content of assimilable sugars. These sugars, being monosaccharides, quickly provide food energy for relieving fatigue due to lack of energy food or to excessive demands upon stored energy.

(A bulletin, "The Nutritive Values of California Prunes," describes the above program in greater detail. A copy will be gladly furnished on request. See coupon.)

Science now knows that Prunes *do not* affect the alkaline reserve

ACCEPTED AMERICAN MEDICAL ASSN Committee on Foods

The potential alkalinity of the ash of California Prunes is 24.4 (cc normal acid per 100 grams of prune flesh).

Prunes, by some, have been thought to yield acid residues in the blood. But the medical profession now knows the the *reverse* is true; and regardless of the presence of benzoic acid in prunes, the addition of substantial quantities to the usual diet has no effect on the alkaline reserve of the blood.

This throws prunes in an entirely new light with respect to the dietary. Patients whose diets are prepared with a view to avoiding foods that are acid in reaction need no longer be deprived of prunes.

Indeed, the results of the most recent scientific research reveal prunes in a more favorable light than ever before. A summary of this work is given here and a booklet describing the detailed results of this research will be gladly forwarded upon request. (See coupon.)

Particular attention is called to the fact that a *second* laxative substance has been discovered in prunes. In addition to the smooth, non-irritating bulk they provide, prunes are now known to contain a *natural laxative substance* (an "active agent") that stimulates intestional action. So distinct is this *second* laxative substance from the roughage that it is present in significant quantity in prune *juice* from which all fibre bulk is lacking.

Thus the prune dressing for English chops given in the recipe printed here, provides, among other things, this *double* intestional stimulation. In addition, it provides *variety* to the diet at very low cost.

California Prunes, in the light of the results of the recent research, and particularly because of their economy, now merit a more prominent place in the hospital as well as the home diet.

Send the coupon today for a copy of the bulletin describing this research work in detail and indicate if you desire additional prune recipes for multiple serving.

A new Manual has also been prepared, describing the place of this delicious fruit in special diets. It is practical and will be helpful to everyone in any way connected with the planning of patients' meals.

A Suggestion: *English Chops with Prune Dressing* (Serves 60)

60 lamb chops, cut 1-inch thick, boned and rolled
Salt and pepper for chops
60 thin slices bacon
3¾ quarts uncooked prunes
10 1-pound loaves bread, crumbled
2½ quarts finely cut celery
1½ quarts finely cut green sweet pepper
4 tablespoons ground sage
Salt and pepper to taste
2½ quarts soup stock

Sprinkle chops with salt and pepper. Wrap each chop with a strip of bacon and hold in place with toothpicks. Boil prunes 10 minutes, drain, cut from pits in small pieces, and combine with bread crumbs, celery, green pepper, sage, salt and pepper, and soup stock; blend thoroughly but lightly. Place in well greased baking pan, and lay chops on dressing. Bake uncovered in a hot oven (450 degrees F.) on high grate for 30 minutes; cover, and continue baking 30 minutes.

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sweetening for some uses, while the next shipment may be flat, so that the cook's stewed tomatoes and Creole sauces will be different every time he serves them. Similar variations are true of all foods. The number of servings per can may also vary.

Then, too, it takes considerably more of the buyer's time if he buys "spot," that is, from different sources as needed, for he should secure competitive prices and make comparisons before purchasing, all of which takes time. When buying from contracts the merchandise will be more uniform. The contract should be made with the understanding that goods can be ordered at intervals as needed. This also simplifies buying.

In preparing lists for future contracts for the first time it is necessary to check back a few years to find just what amount of the various canned foods has been used each year. From this it is quite simple to compile a list of the estimated future year's requirements. Opening prices are usually available by May 1 for all items and as soon as possible afterward the lists should be submitted to the wholesale houses or canneries from which bids are to be secured. Buying direct from the cannery whenever possible is suggested as a means of reducing the food cost. Early prices are frequently lower than later ones. It is advisable to let three or more companies bid on futures.

When making up the lists it is necessary to state the number of dozen cans, the size of the can, the grade, the variety and perhaps the size. For example, "25 dozen No. 2 fancy Golden Bantam corn" or "50 dozen No. 10 extra standard Early June peas, No. 4 sieve." In case of fruits the count and syrup desired may also be given.

Testing Tomatoes

Samples of each item should then be secured and these should be tested by the buyer with perhaps one or two more persons. The things to look for are flavor, solidity of pack or drained weight, and size or general appearance. All samples of tomatoes, for example, should be opened at one time, and the general color, firmness and content noted in the cans. Then they should all be tasted and flavor noted. Next they should be drained through a collander. To do this according to government specifications, a twelve-inch collander with an eight-inch mesh is used. After draining for two minutes without shaking or stirring, the contents of the collander are weighed. This method gives an accurate picture of the serving portions in the can. On this basis the price per ounce should be figured.

In other words, if the appearance and flavor are satisfactory, the can that figures the cheapest per ounce is the one to purchase. It is often found that the better grades will test out cheaper when checked by this method and at the same time they will have better flavor and appearance. It is a rather tedious process to test each canned goods item, but by devoting a special time for it, having all the cans lined up properly and sufficient help to dispose of each food as the tests are completed, it is possible to test a number of different foods in an hour or two.

To be sure, string beans all taste more or less alike after five or six kinds have been sampled, but a drink of ice water refreshes one and testing peaches or plums next also helps. If time permits, it is advisable to extend the can cutting over several days so that a fewer number of items need be taken at one time. The task is strenuous, but it is financially worth while since it ensures the institution of good quality, uniform foods throughout the entire purchasing year.

Save a Sample for Comparison

After the items to be purchased for next year have been selected, it is advisable to secure an additional can of each item and to put these away until the new pack is ready and purchasing against the new contract begins. Then the sample which had been set aside is compared with the new goods coming in. If the new goods does not measure up to the sample, adjustments can be made with the firm supplying the goods.

If the contract is with a wholesale grocery house, it is possible that the new goods may have been purchased from an entirely different canner than the one whose product was tested. A sample of the original item contracted for serves as redress in the event the food purchaser wishes to cancel her contract. This may appear to be a duplication of the work done at the time contracts were made, but it is not.

New canned goods items continue to appear at different intervals from early spring when grapefruit and later asparagus come in, to late fall when apples and applesauce are ready, so that it takes only a few moments to check up on each new item as it becomes available to the dietetic department.

Special Diets Are Listed

Six hospital dietitians contributed various special diets to an article on diet therapy compiled for The HOSPITAL YEARBOOK, just off the press. Lenna F. Cooper presents a general diet; Anna DePlanter Bowes, a children's diet; Ruth Taborn, fever diets; Elsbeth Hennecke, a diabetic diet; Helen B. Anderson, a diet for gout, and Helen Mallory, a high calcium and phosphorus diet. The purpose of the special diet and its modification from the normal are given in each case, along with a day's menu.

November Breakfast and Supper Menus*

By PHYLLIS DAWSON ROWE
Dietitian, Johns Hopkins Hospital, Baltimore

	BREAKFAST		SUPPER				
Day	*Fruit*	*Main Dish*	*Soup or Cocktail*	*Meat*	*Potatoes*	*Salad or Vegetable*	*Dessert*
1.	Orange Slices	French Toast, Syrup, Broiled Bacon	Clear Vegetable Broth	Grilled Chicken Livers With Mushrooms	Hashed in Cream	Tomato and Cucumber Salad	Baked Pears With Whipped Cream
2.	Seedless Grapes	Scrambled Eggs With Little Sausages	Tomato Bouillon	Lamb Chops	Lyonnaise	Marinated Vegetable Salad	Peach Ice Cream
3.	Baked Apples	Fried Pan Trout	Clam Broth	Escalloped Seafood Ramekin	Hashed Brown	Frozen Fruit Salad	Mocha Cakes
4.	Grapefruit	Chicken Livers en Brochette	Beef Broth With Barley	Creamed Sweetbreads and Mushrooms in Patty Shells	Shoestring	Grapefruit Salad	Baked Rice Custard
5.	Stewed Fresh Plums	Poached Eggs on Toast Round	Philadelphia Pepper Pot	Curried Vegetables en Casserole	Baked	Lettuce With French Dressing	Cherry Marshmallow Whip
6.	Honey Dew Melon	Waffles With Honey	Scotch Broth	Minute Steak	Pittsburgh	French Salad	Lady Baltimore Cake
7.	Stewed Apricots	Shirred Eggs	Cream of Asparagus	Chicken Salad	Saratoga	Tomato Slices With Roquefort Cheese Dressing	Caramel Éclairs
8.	Orange Juice	Pan Fried Eggs	Tomato Juice	Ham Steak, Spiced Fruit	Whipped	Perfection Salad	Apple Tarts With Cheese
9.	Preserved Figs	Ham With Scrambled Eggs	Consommé	Mushroom Omelet	Franconia	Pineapple Salad	Fudge Squares
10.	Tokay Grapes	Broiled Bluefish	Green Vegetable	Fried Oysters, Tartare Sauce	French Fried	Lettuce Hearts, Thousand Island Dressing	Pineapple Bavarian Cream
11.	Grapefruit	Maryland Omelet	Chicken Corn	Broiled Beef Patty	Creamed	Waldorf Salad	Prune Cake With Foamy Sauce
12.	Sliced Bananas	Poached Eggs	Southern Bisque	Assorted Cold Cuts	Baked Stuffed	Molded Fruit Salad	Individual Chocolate Coconut Pie
13.	Tomato Juice	Country Sausage	Beef Broth With Barley	Egg Cutlets With Pea Sauce	Oven Fried	Asparagus Salad	Melon Lime Gelatin
14.	Prunes	Coddled Eggs	Cream of Spinach	Lamb Steak	Delmonico	Cucumber and Radish Salad	Baked Stuffed Apples
15.	Orange Sections	Creamed Chipped Beef on Toast	Fruit Cup	Veal Birds	Parsley	Macedoine Vegetable Salad	Caramel Custard
16.	Stewed Figs	Fried Eggs	Tomato Broth	Corn Pudding With Bacon	Shoestring	Celery Hearts, Olives	Fruit Gelatin
17.	Grapefruit Juice	Rice Griddle Cakes, Syrup	Cream of Celery	Shrimp Newburg on Toast	Baked	Perfection Salad	Ivory Cream, Chocolate Sauce
18.	Green Gage Plums	Hash With Poached Egg	Beef Broth With Barley	Creamed Chicken on Toast	Duchesse	Lettuce Hearts With Italian Dressing	Pineapple Ice Cream
19.	Baked Banana	Eggs à la Crème	Onion Soup au Gratin	Assorted Cold Cuts, Mixed Pickle		German Potato Salad	Hot Gingerbread, Whipped Cream
20.	Stewed Raisins	Chicken Livers	Consommé With Green Peas	Sweetbread Cutlets	Creamed Baked	Porcupine Peach Salad	Chelsea Buns
21.	Tokay Grapes	Kidney Stew on Toast	Tomato Bisque	Club Sandwiches	Saratoga		Fruit Cup
22.	Stewed Apricots	Shirred Eggs	Italian Vegetable	Chicken Pie		Coleslaw	Blueberry Cakes With Foamy Sauce
23.	Orange Juice	Creamed Codfish	Chicken Corn	Veal Cutlets, Tomato Sauce	Franconia	Radish Roses	Baked Apples, Whipped Cream
24.	Grapefruit	Poached Eggs		Clam Chowder	Baked	Tomato and Celery Aspic	Fresh Fruit Bowl
25.	Tomato Juice	Wheat Cakes, Syrup and Bacon	Cream of Carrot	Scrambled Eggs With Creole Sauce		Julienne String Beans	Spice Cake With Mocha Frosting
26.	Prunes	Omelet	Tomato Juice	Grilled Lamb Chop	Julienne	Raw Vegetable Relish	Lemon Meringue Pie
27.	Grapefruit Sections	Baked Eggs	Vegetable Creole	Chicken Croquette	Creamed	French Salad	Strawberry Ice Cream
28.	Honey Dew Melon	Pan Fried Eggs	Chicken Rice	Calves Liver and Bacon	Oven Fried	Celery Curls	Apple Dumpling, Foamy Sauce
29.	Pears	Eggs Scrambled With Herbs	Beef Bouillon	Fresh Vegetable Plate With Bacon		Cheese Salad	Old-Fashioned Bread Pudding
30.	Stewed Apples	Waffles With Syrup	German Potato	Cold Sliced Lamb, Grape Jelly	Baked Stuffed	Fruit Salad	Iced Nut Cakes

*Space limitations forbid mention of breakfast cereal, bread and beverage. Recipes for any of the foregoing dishes will be supplied on request by Anna E. Boller, Central Free Dispensary, Rush Medical College, Chicago.

NEWS OF THE MONTH

Health Insurance Considered at Annual Meeting of American College of Surgeons

The necessity for a sound system of health insurance was one of the subjects of interest to hospital people stressed at the annual meeting of the American College of Surgeons which opened in Boston on October 15.

In his inaugural address, the incoming president of the college, Dr. Robert B. Greenough, advocated health insurance as the best means of meeting the economic problem faced by the middle class patient. He stated that it is not to be expected that any single national plan will prove universally satisfactory and that the problem is essentially a local one to be studied and solved locally.

Doctor Greenough divided the middle class into two groups, those on the lower level of income who even when employed cannot be expected to pay all medical costs and those on the upper level who can through insurance meet the entire burden. For the former he advocated assistance from community funds, while for the latter he urged voluntary prepayment of hospital and perhaps medical costs.

Discusses English Payment Plans

Dr. Franklin H. Martin, director general of the college, reported that 2,480 of the 3,538 hospitals of twenty-five beds or more that had been surveyed by the college had been fully or provisionally approved, an increase of 104 over last year's list.

The hospital standardization conference was opened by Dr. William D. Haggard of Nashville, Tenn., president of the college. Sydney Lamb of Liverpool, England, described the development of English periodic payment plans for hospital care. Rev. A. M. Schwitalla, dean, St. Louis School of Medicine, read a scholarly paper on "The Hospital in Retrospect and Introspect," pointing out the need of standardization regarding much of the work of hospitals but making a strong plea for retention by hospitals of their own individualities.

Despite financial difficulties and other limitations now put on hospital service, American hospitals have always made it their goal to give every sick patient the advantage of all services and facilities that would help to cure him, declared Dr. Bert W. Caldwell, executive secretary of the A. H. A. He urged the continuance of this aim in spite of present day difficulties.

Dr. Arthur C. Christie, chancellor of the American College of Radiology and chairman of its committee on medical economics, presented a series of "principles" which he proposed should govern the relation of radiologists to hospitals. The essence of these principles is that the radiologist should have the same financial relation to the hospital and to patients in the hospital that the surgeon has except that the radiologist may be paid a salary for teaching, research or service to free patients. Since there was no discussion of the principles it was impossible to determine how they were received.

Dr. Donald A. Balfour, president-elect.

The Monday afternoon session was devoted to a symposium on the care of obstetrical cases in the hospital. Dr. George W. Kosmak presided.

The inaccuracy of judging the efficiency of an obstetrical service purely on the basis of maternal mortality was pointed out by Dr. George Gray Ward, chief surgeon, Women's Hospital, New York City. Those wishing to judge should know the morbidity as well as the mortality, he said, but morbidity cannot be determined solely on the basis of elevated temperature. As evidence of this statement he presented a list of serious complications that had occurred on his service in which there was no elevation of temperature.

If morbid conditions arising prepartal, intra partum and postpartum are carefully recorded and tabulated a surprising total of complications is found to occur, said Doctor Ward, who cited 600 complications or morbid conditions occurring in 1,300 deliveries. He urged a standard method of judging and recording maternal morbidity that would include more than mere recording of elevated temperature and would cover the period from the beginning of pregnancy to the completion of involution of the uterus after delivery.

The desirability of admitting courtesy physicians for obstetrical work in hospitals under rigid and impartial supervision was stressed by Dr. Samuel A. Cosgrove, medical director, Margaret Hague Maternity Hospital, Jersey City, N. J. Doctor Cosgrove reported that of 600 patients delivered in his institution by courtesy men none had died.

The Tuesday morning session was devoted to discussions of sterilization of surgical material and to surgical wound infections. The mechanics and technique of sterilization were described by Hurly T. Wyatt, Madison, Wis., who illustrated his talk with large scale drawings of hospital sterilizers and models of important traps and valves.

Weeden B. Underwood, Erie, Pa., in a paper read for him, discussed scientific studies of the use of steam sterilizers and advocated the use of precision methods of sterilization instead of the indefinite methods now in vogue. He made a special plea that bacteriologists furnish sterilizer engineers with more definite information as to the thermal death points of various pathogenic and nonpathogenic bacteria, indicating that such information would be of real assistance in the perfection of sterilizing processes. Both speakers agreed that sterilization is most often inefficient because of inadequate expulsion of air from the sterilizing chamber.

Describes Study of Sterilization

An extensive study of sterilization that has been carried on in St. John General Hospital, St. John, New Brunswick, indicates that dependence cannot be placed entirely upon readings of steam pressure gauges or of the ordinary type of recording thermometers, according to Dr. S. R. D. Hewitt, superintendent. He found that temperatures within the centers of large packages in the sterilizers were

NEWS OF THE MONTH

often considerably less than the temperatures indicated by the thermometer or the steam pressure. It takes about thirty minutes at fifteen pounds pressure, he indicated, to reach the desired sterilizing temperature of 255° F. in all parts of the sterilizer load. Therefore when a sterilizer is run at this pressure for one hour, only the second half hour can be counted on as actually producing the required heat in the center of the load.

In discussing these two papers, Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y., paid a tribute to the high quality of the firms serving hospitals, such as the sterilizer companies whose representatives appeared on this program. When surgical infections occur hospitals usually suspect the catgut or dressings, although on careful investigation, Doctor Munger said, he had found that some act or omission of the doctors or nurses was usually responsible.

Reducing Wound Infections

Standards to be followed and precautions to be observed by hospital surgical services to keep wound infections at a minimum were outlined by Dr. Harold L. Foss, surgeon in chief, George F. Geisinger Memorial Hospital, Danville, Pa. In 7,600 consecutive surgical cases in his service, Doctor Foss reported that 7.3 per cent had some kind of complication. Of these complications, 65 per cent had to do with the wound. He exhibited a "complication record" which ward supervisors in his hospital are required to fill out for all surgical cases, giving complete details concerning wound infections and other postoperative complications.

The afternoon meeting was held at the Massachusetts General Hospital under the chairmanship of Dr. George H. Bigelow, director. The organization of the anesthesia service was outlined by Dr. Howard Bradshaw, anesthetist. It provides for medical supervision and control and training of physicians and nurses in anesthesia.

The importance of social problems in orthopedic, diabetic, cancer and plastic surgery cases was demonstrated by Ida M. Cannon, chief, social service department, Massachusetts General Hospital. Miss Cannon presented a series of case histories of patients who had been subjected to long and serious surgical treatment and described the mental problems that arose.

Dr. Morgan J. Rhees, assistant director of the hospital, outlined in detail the first four and one-half years' experience of the Baker Memorial Pavilion for patients of moderate means. He indicated that this attempt to assist middle class patients was proving of real value to them and that the patronage of the pavilion was steadily increasing. To date it has not been possible to operate the pavilion without a deficit, he said, but this deficit appears to be steadily decreasing and it is expected that as soon as a 66 per cent occupancy is reached the pavilion will become self-supporting.

An exhaustive study of the operation of the eight-hour day for special duty nurses in the hospital showed the plan to be successful and desirable, according to Sally Johnson, superintendent of nurses. Eighty-one per cent of the staff doctors, 84 per cent of a sample of 250 patients and 100 per cent of 125 nurses questioned about the plan approved it. Miss Johnson indicated that nearly all the doctors and patients believe it is unfair to expect nurses or any other group to work twelve hours a day.

Following the conference the eighty-fifth annual celebration of Ether Day was observed. The first administration of ether for a surgical operation occurred under the "ether dome" of Massachusetts General Hospital. Dr. Frederic A. Washburn delivered the Ether Day oration, taking as his subject "The Hospital Then and Now."

Dr. Donald A. Balfour, Mayo Clinic, Rochester, Minn., was chosen president-elect of the college.

$612,500 Claim Allowed Chicago Institution

Probate Judge John F. O'Connell on October 24 allowed a claim of $612,500 plus $89,063 interest against the estate of Edith Rockefeller McCormick. The claim had been filed in behalf of the John Rockefeller McCormick Memorial Institute for Infectious Diseases, Chicago, which had been founded in 1902 by Mrs. McCormick and her former husband, Harold F. McCormick.

The matter has been in litigation for many months and was based on a written agreement made by Mrs. McCormick in 1917 in which she promised to endow the institute with $612,500. The endowment fund, however, was not to be paid to the institute until 1947 and until that time Mrs. McCormick agreed to pay to the institute interest on that amount at the rate of 4 per cent a year. A similar agreement was entered into by Harold F. McCormick.

The law firm of Cutting, Moore & Sidley, counsel for the Chicago Title and Trust Company, executor of the estate, was undecided at the time whether an appeal would be taken from Judge O'Connell's ruling.

Gets $100,000 Bequest

The New York Hospital, New York City, benefits to the amount of $100,000 in cash through a bequest made in his will by Edward Wright Sheldon, chairman of the board of the United States Trust Company. The Society of the New York Hospital is the legatee.

Group Hospitalization Progresses in New York

Group hospitalization in New York City took one more step forward at a recent meeting of the Hospital Conference of the City of New York and the Brooklyn Hospital Council when it was announced that a corporation has been chartered by the Secretary of State and contracts will be ready for the hospitals to sign in a few weeks.

The new corporation is called the Associated Hospital Service of New York and has a board of directors of eleven members. The voting membership of the corporation comprises the presidents of the Hospital Conference of the City of New York, the Brooklyn Hospital Council, the five county medical societies of greater New York, the Academy of Medicine, the Medical Society of the State of New York and the trustees of the United Hospital Fund.

The original members of the board of directors are as follows:

William C. Breed, Jr., Rev. Joseph F. Brophy, Dr. Walter T. Dannreuther, Robert J. Eidlitz, Karl Eilers, Dr. S. S. Goldwater, G. Beekman Hoppin, Henry Moir, Donald Price, Stanley Resor, and Dr. T. Dwight Sloan.

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QUIET CASTERS

NEWS OF THE MONTH

Four New Names Added to Editorial Board

Dr. G. Harvey Agnew, secretary, Canadian Hospital Council, Toronto, has accepted a position on the editorial board of The MODERN HOSPITAL. Doctor Agnew's work with the Canadian Hospital Council has been outstanding and he is generally recognized on both sides of the border as an authority on hospital problems. In part through his efforts, the Canadian hospitals and the Canadian Medical Association have maintained close and effective cooperation on all problems affecting both bodies.

Others who have recently joined the magazine's editorial board are:

John R. Mannix, assistant administrator, University Hospitals of Cleveland, and president, Ohio Hospital Association, whose contributions to hospital work for many years have given him a position of leadership in the field unusual for one of his age.

Frank J. Walter, superintendent, St. Luke's Hospital, Denver. Mr. Walter was president of the Colorado Hospital Association for many years but resigned last year. He is well known for his interest in the problem of automobile accidents.

Dr. George F. Stephens, superintendent, Winnipeg General Hospital, Winnipeg, Canada. Doctor Stephens is not a new member of the editorial board, having served prior to his term as president of the American Hospital Association. He resigned on election to the presidency so that he could devote his full efforts to that task.

Record Librarians Meet in Boston

Meeting in Boston on October 15 for the first time since the organization was formed there six years ago, the Association of Record Librarians of North America was able to show a healthy growth and substantial achievements during that short period. More than 100 members registered for the meeting and it was reported that over 300 librarians have now been registered as approved. An interesting educational exhibit was a feature of the meeting.

The most important action taken at the meeting was the acceptance of a report on education of record librarians which contained a standard curriculum for a six months' course. The education committee was asked to inspect and approve any schools for record librarians that meet the standards it has set up. It reported that no schools were yet ready to meet these standards but that several schools approximated them closely enough to merit conditional approval.

Edna Huffman, librarian, St. Luke's Hospital, Davenport, Iowa, was installed as president and Billie Haig, librarian, Memorial Hospital, Houston, Tex., was chosen as president-elect. It was also decided to increase the association's bulletin from sixteen to twenty pages.

Schedule Announced for Special Radio Programs

A series of radio broadcasts on medical and hospital economics has been arranged by the National Advisory Council on Radio in Education and is being presented every Monday evening over a Columbia coast-to-coast network. The series started on October 1 and there were four broadcasts during October.

The next broadcast will be on Monday evening, November 19, when Dr. Thomas Parran, Jr., commissioner, New York State Department of Health, will speak on "Public Health Needs." This broadcast like the others will be given at 10:45 p.m. Eastern standard time. The balance of the series is as follows:

Nov. 26—Dr. George H. Bigelow, director, Massachusetts General Hospital, Boston, "Preventive Medicine."

Dec. 3—Dr. Nathan B. Van Etten, New York City, "Abuses of Medical Charity."

Dec. 10—Dr. Ray Lyman Wilbur, president, Stanford University, former president, American Medical Association, "The Doctor's Part in Medical Care."

Dec. 17—Professor Paul H. Douglas, University of Chicago, "Uneven Costs of Sickness; How to Meet Them."

Dec. 24—William Trufont Foster, director, Pollak Foundation, New York City, "Tiny Tims of Today."

Dec. 31—Michael M. Davis and C. Rufus Rorem, Julius Rosenwald Fund, Chicago, "Progress in 1934."

Jan. 7—Frank Van Dyk, executive secretary, Hospital Council of Essex County, New Jersey, and Homer Wickenden, general director, United Hospital Fund, New York City, "Budgeting Hospital Bills."

Jan. 14—Katherine Tucker, general director, National Organization for Public Health Nursing, Inc., "The Nurse's Part in Medical Care."

Jan. 21—Nathan Sinai, director of research, Michigan State Medical Society, "Mutual Health Service."

Jan. 28—William Hard, journalist, Washington, D. C., "The Government's Part in Medical Care."

Feb. 4—Dr. Haven Emerson, College of Physicians and Surgeons, New York City, and former president, American Public Health Association, "The Future of Medical Care."

Feb. 11—I. S. Falk and Edgar Sydenstricker, Milbank Memorial Fund, New York City, "Present Trends in Health Insurance."

Feb. 18—Harry H. Moore, former director of study, Committee on the Costs of Medical Care, "The Man From Mars Asks Questions."

Feb. 25—Dr. Livingston Farrand, president, Cornell University, "Next Steps."

The purpose of the series is stated to be not "to advocate any one solution of the problem (of bringing doctors, dollars and diseases into such helpful and continuous contact with each other that the practice of medicine can keep pace with the science of medicine) but to furnish reliable information and stimulate discussion."

N. J. Hospitals Win Milk Price Battle

Hospitals in New Jersey are no longer required to pay minimum prices for milk and cream, it was announced recently by the State of New Jersey Milk Control Board. Effective October 1, the control board amended its Official Orders B-1 and B-4, thus granting hospitals in the state the privilege of negotiating with suppliers for their milk and cream requirements without interference by the board.

The Hospital Council of Essex County, Newark, N. J., of which Frank Van Dyk is executive secretary, led the campaign to eliminate the minimum price restriction for hospitals.

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Mt. Carmel Hospital, *Columbus, Ohio.*
U. S. Marine Hospital, *Detroit, Mich.*
St. Mary's Hospital, *Detroit, Mich.*
Beth Moses Hospital, *Brooklyn, N. Y.*
Mineola Hospital, *Mineola, L. I.*
St. Barnabas Hospital, *Newark, N. J.*
Fort Monmouth Hospital, *Fort Monmouth, N. J.*
N. J. Hospital for the Insane, *Holmdel, N. J.*
Meadowbrook Hospital, *Meadowbrook, N. Y.*
Huntington Hospital, *Huntington, L. I.*
Northampton State Hospital, *Northampton, Mass.*
St. Joseph Hospital, *Chicago, Ill.*
Des Moines General Hospital, *Des Moines, Iowa.*
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NEWS OF THE MONTH

American Dietetic Association Holds Successful Meeting in Washington, D. C.

The dietitians spent the week of October 14 in Washington, attending the seventeenth annual meeting of the American Dietetic Association. The meeting opened with a tea on Sunday and closed with a luncheon at the Johns Hopkins Hospital in Baltimore on Saturday.

The professional program included many addresses of timely interest, such as "The Present Food Situation," by Mordecai Ezekiel, economic adviser to the Secretary of Agriculture; "Emergency Relief and the Dietitian," by Marjorie Heseltine, nutritionist, Federal Emergency Relief Administration; "What the Bureau of Home Economics Does for the Consumer," by Louise Stanley, chief, Bureau of Home Economics, U. S. D. A.; "Community Canning Centers as Relief Projects," by F. W. Tanner, department of bacteriology, University of Illinois, and "Nutrition Findings of Food Committees of Home Stabilization Organizations," by Marie Dye, division of home economics, Michigan State College.

Offers Practical Suggestions

At the administration section were presented many topics of interest to the hospital dietitian. "The Dietitian as an Administrator" was the subject discussed by Erwin H. Schell, department of business and engineering administration, Massachusetts Institute of Technology, Boston. The speaker made practical suggestions as to the handling of a department. Mary Lindsley presented the subject, "Carry On With What We Have."

Emma Hahm of the Allies Inn, Washington, speaking on "Maintaining Food Standards," said that two factors are important in serving food to the public — the food must be fresh before it is cooked, and it must be served promptly. Small pans such as are used in the home are a great help in cooking vegetables to maintain their natural color and flavor.

Lorena Richardson, Simpson's Arcadian Court, Toronto, outlined the need for good administrators. She expressed the belief that there is a dearth of persons who are willing to assume responsibility. She also stressed the point that a good executive makes a decision with the knowledge that even if she errs, the department will go ahead, because she will profit by the experience. The best administrator, the speaker said, is the one who makes the maximum number of decisions with a minimum number of mistakes. She urged action and prompt decisions, unhampered by the fear of errors.

Other papers of interest to administrators dealt with the importance of lighting and air conditioning.

Papers on Scientific Subjects

The scientific aspect of the field was well covered by such papers as "Recent Trends in Vitamin Research" by R. Adams Dutcher, head of the department of agricultural and biological chemistry, Pennsylvania State College. Mr. Dutcher outlined briefly the newer ideas about vitamins and by means of charts presented a graphic picture. Ernestine Becker, associate, department of biochemistry, Johns Hopkins School of Hygiene and Public Health, talked on "The Irradiation of Foods," a subject of vital interest to everyone today. Dr. M. E. Rehfuss, Philadelphia, discussed "Diet and Dietary Faddism." In connection with the paper on "Classification of Fruits and Vegetables According to Their Carbohydrate Content," by Georgian Adams, Bureau of Home Economics, helpful charts were distributed.

A number of papers of general interest were presented. The first of these was by Genevieve Forbes Herrick, president of the Women's Press Club, Washington, on "Official Washington." For those who did not know Washington, this paper was especially fascinating. Malvina Lindsay, editor, women's pages, *Washington Post*, emphasized the dietitian's responsibility in demanding and providing well founded material for newspaper publicity. Richard H. Waldo, president, McClure Newspaper Syndicate, New York City, gave the group a new sense of their importance in determining the policies of the nation.

One of the most charming features of the program was the paper by Kenneth Chorley, Rockefeller Center, New York City, on "The Restoration of Colonial Williamsburg." The word picture presented by Mr. Chorley created such interest that many of the dietitians prolonged their stay by taking the two-day cruise down Chesapeake Bay to Williamsburg.

The tea at the Dodge Hotel on Sunday was probably the outstanding social feature of the convention. Mary Lindsley of the Dodge was hostess and presided with her usual charm. The presence of distinguished guests from official Washington made the afternoon most delightful. At the banquet on Wednesday night entertainment was provided by the United States Navy Band and the Sabbath Jubilee Singers, the former provided by the Washington association and the latter by the Richmond group.

The more formal program was concluded on Thursday. Friday was spent in sightseeing and visiting points of professional interest. At least 150 delegates remained for the delightful day at Johns Hopkins Hospital, Baltimore.

Ruth Atwater, president of the District of Columbia Dietetic Association and chairman of the Committee on Local Arrangements, and her able group were commended for their work.

The incoming officers have already started their activities for the coming year by deciding that the 1935 meeting will be held in Cleveland.

The New Officers

Officers for the coming year are as follows: president, Laura Comstock, Eastman Kodak Company, Rochester, N. Y.; president-elect, Katherine Mitchell, Michael Reese Hospital, Chicago; first vice president, Lute Troutt, Indiana University Hospitals, Indianapolis; second vice president, Ruth Atwater, National Canners' Association, Washington, D. C.; secretary, Beula B. Marble, Collis P. Huntington, Memorial Hospital, Boston, and treasurer, Ella Marie Eck, University of Chicago Clinics.

The following section chairmen were chosen: administration, Anna M. Tracy, Florida State College for Women, Tallahassee; diet therapy, Werginia Speicher, Indiana University Hospitals, Indianapolis; professional education, Lenna F. Cooper, Montefiore Hospital, New York City, and community education, Mary I. Barber, Kellogg Company, Battle Creek, Mich.

NEWS OF THE MONTH

Hospital Laboratories Cost Two Million a Year

The United Hospital Fund of New York, in a survey made public on October 7, announced that forty-nine New York hospitals spend approximately $2,000,000 a year maintaining laboratory and x-ray departments, incurring a deficit of about $500,000. The cost of these departments, the report brought out, is about 8 per cent of the total cost of operating the hospitals.

One of the reasons for the deficit, the report says, is that 41.8 per cent of hospital services in the forty-nine institutions studied is free.

"The data indicate the tremendous importance of x-ray and laboratory departments in voluntary hospitals, and the large proportions which such work has attained," said Dr. Eleanore Conover, assistant director of the fund's hospital information service, which prepared the report.

Doctor Agnew Seriously Injured in Accident

Dr. G. Harvey Agnew, secretary, Canadian Hospital Council, Toronto, was seriously injured as the result of an accident which occurred on October 20.

The accident happened when Doctor Agnew, who was transplanting flowers, slipped and fell from a balcony. The fall, which was about twenty-five feet, broke Doctor Agnew's back, injured his right arm and caused a concussion. The latest reports state that permanent injury is not anticipated but that a long convalescence will be required.

Work Progresses on N. Y. Jewish Hospital

With a view to having the new Jewish Memorial Hospital at Broadway and 196th Street, New York City, ready for occupancy by May 1, 1935, work is being speeded on this new structure. The new hospital, including land and equipment, will represent an investment of about $1,250,000, of which $350,000 is being advanced in the form of a PWA loan which is to be paid back over a thirty-year period.

The capacity of the new building will be almost double that of the hospital's present headquarters at Dyckman Street, comprising 179 adult beds and 30 children's beds.

In the new structure there will be eight stories, on the first floor of which space will be provided for interns' rooms, the social service department and pharmacy; on the second floor, the dispensary, physiotherapy and x-ray laboratories, and on the third floor, rooms for children and male patients. Women patients will be cared for on the fourth floor, and the maternity and nursery facilities will be on the fifth. The sixth floor will be devoted to private rooms.

On the seventh floor will be the operating and delivery rooms, also the pathological laboratory. A solarium for convalescents will occupy the eighth floor.

Plans for the new hospital were drawn by Charles B. Meyers, architect.

Mills Points Out Problems in Health Insurance

Important questions to be answered before the public turns to a program of health insurance or state medicine were outlined by Alden B. Mills, managing editor, The MODERN HOSPITAL, who told a round table group at the annual Ohio Welfare Conference, held recently at Cincinnati, that "we must have either health insurance or state medicine to bring medical care within the reach of all the people."

"If we are to have health insurance, we must decide whether it shall be for those in the low income groups or for all the population," Mr. Mills said. "We must decide whether we shall have a separate system for the indigent maintained by the government entirely and another for the general public or whether both groups will be served by one system under government supervision."

It must also be decided whether the health insurance plan will provide for the sick and injured only or whether it will receive sufficient financial support to take up the work of preventive medicine, Mr. Mills pointed out.

"Shall health insurance be voluntary or compulsory for those who are on public funds?" "Shall health insurance funds be set up from contributions of employers and employees or through taxation?" "Shall health insurance be of national scope or carried on by the states under federal administration?" Decisions on these questions must be reached, Mr. Mills explained.

Warren S. Thompson, Scripps Foundation for Research in Population Problems, Miami University, Oxford, Ohio, spoke on "Future Population Trends and Their Significance to Health."

The speaker pointed out that if present specific birth rates continue unchanged in the United States we shall have an excess of deaths over births within two or three decades. Effective health work for old people will necessitate reorganization of the present set-up in the health field, Mr. Thompson remarked. He feels that public health workers should abandon crude death rates and give rates by ages. Postponement of the attack of degenerative diseases is the great future health problem, Mr. Thompson said.

Coming Meetings

University Hospital Executives Council.
Chairman, Dr. H. A. Haynes, University of Michigan.
Secretary, John C. Dinsmore, University of Chicago.
Next meeting, University of Minnesota, Nov. 16-17.

Western Hospital Association.
President, Dr. J. Rollin French, Golden State Hospital, Los Angeles.
Secretary, Lola M. Armstrong, *Western Hospital Review*, Los Angeles.
Next meeting, San Francisco, Feb. 18-21, 1935.

Ohio Hospital Association.
President, John R. Mannix, University Hospitals, Cleveland.
Executive secretary, A. E. Hardgrove, City Hospital of Akron, Akron.
Next meeting, April, 1935.

Iowa Hospital Association.
President, Thomas P. Sharpnack, Broadlawns Hospital, Des Moines.
Secretary, Erwin C. Pohlman, University Hospitals, Iowa City.
Next meeting, Iowa City, April 29-30, 1935.

Hospital Association of Pennsylvania.
President, Charles A. Gill, Episcopal Hospital, Philadelphia.
Executive secretary, John N. Hatfield, Pennsylvania Hospital, Philadelphia.
Next meeting, Philadelphia, May 8-10, 1935.

Mississippi Hospital Association.
President, Dr. R. J. Field, Field Memorial Hospital, Centreville.
Secretary, Dr. Leon S. Lippincott, Vicksburg Sanitarium & Crawford Street Hospital, Vicksburg.
Next meeting, Biloxi, May 13, 1935.

Hospital Association of Nova Scotia and Prince Edward Island.
President, Rev. H. G. Wright, Inverness, Nova Scotia.
Secretary, Anne Slattery, Dalhousie University, Halifax, Nova Scotia.
Next meeting, Wolfville, Nova Scotia, June, 1935.

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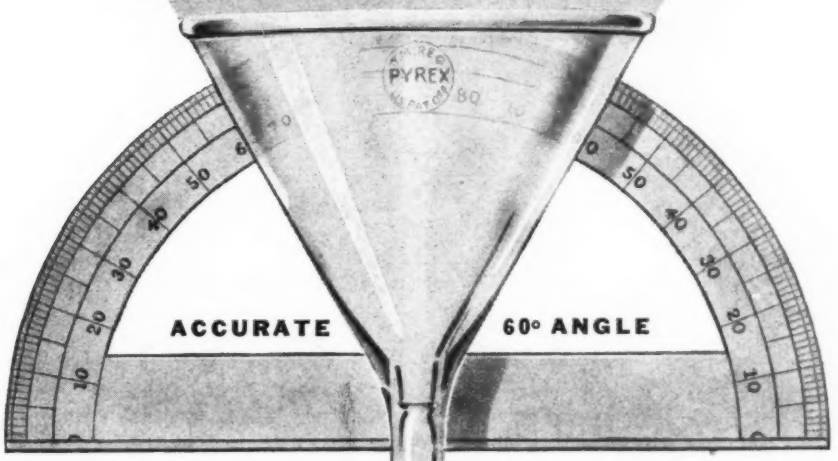

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Diam.	*Length of Stem*	*Quan. Per. Pkg.*	*Net Price Each*	*Net Price Per Package*			
				1 Pkg.	25 Pkgs.	50 Pkgs.	100 Pkgs.
65 m/m	150 m/m	72	$.35	22.68	21.55	20.41	19.28

Made in one size only, 65 mm diameter by 150 mm stem length.

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NEWS OF THE MONTH

A. M. A. Editor Backs Hospital Insurance at Meeting Held in Rochester, N. Y.

An apparent change of attitude toward group hospitalization on the part of the American Medical Association was reflected in a recent address by Dr. Morris Fishbein in Rochester. The following article is from the Rochester *Democrat and Chronicle* of October 23.

" 'Hospital insurance plans such as those proposed by the Hospital Council of Rochester are feasible so long as they maintain the present responsibility between doctor and patient.'

"In these words Dr. Morris Fishbein of Chicago, editor of the *Journal of the American Medical Association*, last night gave qualified approval to the program. Guest of the Temple Club, B'rith Kodesh Congregation, Doctor Fishbein endorsed the hospital plan, but assailed socialized medicine as 'cheap medicine.'

" 'The plan of committing individuals to pay a nominal sum annually as insurance for hospital care when it will be needed is a sound and feasible one,' he said. 'The American Medical Association has given its endorsement, provided individual responsibility between doctor and patient is maintained. It should be a voluntary and not compulsory program and doesn't mean much unless there is cooperation among all hospitals in the community.

" 'What we really need is education to persuade people to save for sickness as they do for other things.'

"Maintaining his faith in democracy as against regimentation, Doctor Fishbein characterized plans for socialized medicine as panaceas provided by politicians to keep the people from becoming too discontented. As such they were put into effect in England and in Germany, he said.

"As for old age pension plans, they should be handled by the states rather than by the national government, the speaker declared, because of varied conditions throughout the country.

" 'The medical profession is certainly responsible for prolonging life,' he said. 'Whereas fifty years ago life expectancy was forty-three years, now it is sixty years. A good many people who a generation ago would have died off in their fifties now linger on into old age. Since man can't work after seventy, his economic dependence should be met by state pensions.'

"Advances may have been made, but the American public still has to forget a good many fads if it would win its way to sane health programs, the speaker declared."

Immunization of Medical Students and Nurses

Diphtheria in medical students and nurses is a significant problem. While the susceptibility rate in this age period is not as high as in children under ten years of age, the number of susceptibles among individuals twenty years of age and older is sufficiently high to warrant an attempt at immunization, especially since they are exposed frequently to this disease, according to the *Journal of the American Medical Association.*

Attempts to immunize students and nurses against diphtheria have led to the following conclusions:

1. Results reported show that it is possible to immunize students and nurses against diphtheria with diphtheria toxoid without producing any undesirable general or local reactions. The same procedure can be applied to the civil population under conditions in which immunization against diphtheria is indicated.

2. By testing intradermally with a skin test dose of dilute toxoid each person in the older age groups who has a positive Schick test, those individuals in whom a severe reaction would occur following a subcutaneous injection of toxoid can be detected.

3. Those who have a negative toxoid skin test can be given the usual dosage of diphtheria toxoid, while the dilute toxoid should be given to those who have a positive toxoid skin test or "toxoid reaction test."

4. The desirability of using diphtheria toxoid to replace diphtheria toxin-antitoxin mixture as an immunizing agent is emphasized.

International Congress Will Be Held in Rome

The fourth International Hospital Congress will be held in Rome, Italy, May 5 to 12, 1935. The Italian government, the various national hospital associations, the International Council of Nurses and the International Hospital Association will be represented by speakers at the opening session.

Before the congress, a study trip through the large Italian towns north of Rome will be made. After the congress there will be a study trip or pleasure trip through Southern Italy, including Sicily and Tripoli.

Mrs. Armstrong Dies From Convention Auto Crash

Mrs. Harry T. Armstrong, wife of the assistant manager of St. Luke's Hospital, Bethlehem, Pa., died on September 27 as the result of injuries suffered the previous day when an automobile and a bus, both loaded with persons attending the recent convention of the American Hospital Association, collided. Jean Coucheuer, director of the school of nurses at St. Luke's Hospital, was killed immediately.

Katherine Mavri, a nurse at the same hospital, suffered a fractured skull and a fractured pelvis. Miss Mavri is reported getting along very well and her complete recovery is anticipated. Frances Parkinson, also a nurse at the hospital, was less seriously hurt.

Western Hospital Association Reorganizes

A reorganization of the Western Hospital Association and the moving of its offices to San Francisco are announced in the October issue of the *Western Hospital Review.* After November 15 the offices will be in the Whitcomb Hotel, San Francisco, instead of in Los Angeles as heretofore.

In addition a policy has been adopted of trying to develop in each of the eleven member states a state hospital association as a constituent part of the W. H. A. A committee for this purpose has been appointed in California. The Washington State Hospital Conference recently changed its name to the Washington Hospital Association.

PERSONALS

JAMES ROGERS of Drumheller Municipal Hospital, Drumheller, Alberta, Canada, was elected secretary-treasurer of the Alberta Hospitals Association at the recent meeting of the association held in Edmonton, Alberta.

MARY A. LARGE of Wilmette, Ill., has been appointed superintendent of Iroquois Hospital, Watseka, Ill., succeeding HELEN JOHNSON, who has resigned after having served in that position for nearly four years.

CAROLINE HOGUE, superintendent of Woodlawn Hospital, Rochester, Ind., has resigned her position.

REV. SAMUEL W. ROBINSON of Flint, Mich., has been appointed superintendent of Bronson Methodist Hospital, Kalamazoo, Mich., succeeding REV. WILLIAM M. PUFFER.

DR. JOHN ALLEN THAMES, who was appointed superintendent of East Louisiana State Hospital, Jackson, on September 1, died of a heart attack at Harvey, La., on September 30.

DR. G. CANBY ROBINSON, who has received a year's leave of absence as director of the New York Hospital and the Cornell Medical College, has been appointed visiting professor of medicine at Peiping Union Medical College, Peiping, China. Doctor Robinson will assume his new duties on December 1.

MURRAY SARGENT has been appointed to the newly created post of assistant to the president of the New York Hospital, New York City. Mr. Sargent, who is also director of the New Haven Hospital, New Haven, Conn., will have charge of the medical center.

DR. N. STANLEY LINCOLN has been appointed superintendent of the Hermann M. Biggs Memorial Hospital, which is now being constructed by the state at Ithaca, N. Y.

DR. RALPH HORTON has been named superintendent of the new state tuberculosis hospital which is under construction at Oneonta, N. Y.

MRS. E. PALMER has been named superintendent of the Florence Crittenton Home, Newark, N. J.

DR. C. S. TENNANT, formerly superintendent of Ontario Hospital, Woodstock, Ontario, Canada, is now superintendent of Ontario Hospital at Brockville, Ontario. DR. B. O. LYNCH is the new superintendent at the Woodstock institution.

DR. GEORGE STEVENSON has been appointed superintendent of Ontario Hospital, London, Ontario, Canada.

COL. THOMAS MORRISON is the new superintendent of Westminster Hospital, London, Ontario, Canada.

CONSTANCE M. JOHNSTON was recently named superintendent of Niagara Falls General Hospital, Niagara Falls, Ontario, Canada.

DR. C. A. MCCLENAHAN has been appointed superintendent of Ontario Hospital, Penetanguishene, Ontario, Canada.

MYRTLE BEHILE has been named superintendent of Monte Vista Hospital, Monte Vista, Colo.

SISTER M. ODILO is the new superintendent of St. Mary's Hospital, Superior, Wis.

MISS KAPULANI MAKAHANOHANO has been appointed superintendent of Mululani Hospital, Wailuku, Maui, Hawaii.

GERTRUDE T. HAYNES has been named superintendent of Walker County Hospital, Jasper, Ala.

SISTER M. ELENA is the new superintendent of St. Mary's Hospital, Cairo, Ill.

CARRIE E. HAUGEN is now superintendent of Physicians' Hospital, Thief River Falls, Minn.

H. F. DOLD has been appointed superintendent of Homeopathic Medical and Surgical Hospital, Reading, Pa.

HAZEL KNIBB is now superintendent of Grace Hospital, Richmond, Va.

NELLIE G. BROWN, superintendent of Ball Memorial Hospital, Muncie, Ind., has been elected president of the Indiana State Nurses' Association.

DR. JOHN GORRELL, for the past two and a half years assistant to the superintendent of the University of Chicago Clinics, resigned on October 1 to assume the superintendency of the Falk Clinic, University of Pittsburgh.

MARGARET HALES ROSE has resigned as superintendent of Washington County Hospital, Washington, Iowa, after five years' service in that position, to accept the superintendency of Wichita Falls General Hospital, Wichita Falls, Tex.

SISTER M. CAMILLUS has assumed the superintendency of Charlottetown Hospital, Charlottetown, Prince Edward Island, Canada.

SISTER O'GRADY is the new superintendent of St. Paul's Hospital, Saskatoon, Saskatchewan, Canada.

I. M. HERMAN has been named superintendent of Missouri Pacific Hospital, Little Rock, Ark.

MARGERY LEE is the new superintendent of Shriners' Hospital for Crippled Children, Chicago.

E. HEARST is now superintendent of Sartori Memorial Hospital, Cedar Falls, Iowa.

HELEN MAHAFFY has been appointed superintendent of Hayes-Green Memorial Hospital, Charlotte, Mich.

SISTER MARY ESTHER is now superintendent of St. Peter's Hospital, Albany, N. Y.

HARRIET SANFORD has been named superintendent of Cuba Memorial Hospital, Cuba, N. Y.

MARGARET HAMILTON has assumed the superintendency of Potter Emergency Hospital, Beaufort, N. C.

LUCILLE BROOKS is the new superintendent of Kingsport General Hospital, Kingsport, Pa.

FREDA BREAKER has been named superintendent of Maple Crest Sanatorium, Whitelaw, Wis.

DR. W. W. PETER, active in public health here and abroad, has been appointed medical director of the new consolidated Navajo Reservation.

Rockefeller Institute to Expand Facilities

According to plans filed with the building department in Manhattan, alterations are to be made to the Rockefeller Institute of Medical Research, New York City, at a cost of $1,500,000. The architects selected are Coolidge, Shepley, Bulfinch & Abbott of Boston.

BOOKS ON REVIEW

AN ALPHABETICAL NOMENCLATURE OF DISEASES AND OPERATIONS. *By T. R. Ponton, B.A., M.D. Chicago: Physicians Record Company,* 1934. $4.75.

Hospitals already using Doctor Ponton's nomenclature will be pleased with the new edition just published. Others who are considering changing nomenclature systems will want to see this one before making a selection.

A valuable feature, and a revolutionary one in nomenclatures, is found in the loose-leaf arrangement and attractive ring binding that have been adopted. No classification of diseases has yet been devised that is not subject to correction and change. In the past, hospitals have been put to considerable expense in purchasing a full equipment of new books every few years.

The nomenclature of operations that is included should be deeply appreciated by record librarians who have found the cross file of operations a difficult task under other systems. The book will be purchased for this section alone, even by hospitals using other disease classifications.

Both diagnostic terms and anatomic regions are listed alphabetically in separate parts of the book and are separately coded. This edition also involves a complete change of numbering of diagnostic terms. By the use of two lengthy numbers a diagnosis may be mechanically coded although the author's instructions indicate indifference as to whether the cross file is controlled numerically or alphabetically, with preference for the latter in smaller hospitals.

The present reviewers are inclined to question whether this nomenclature is the equal of at least one other in providing a cross file that will distinguish between the more intricate shadings of closely related diagnoses. Except in the larger hospitals, these elaborations of diagnosis are probably not attempted and this objection might be considered more academic than practical. If all hospitals utilized this nomenclature to its limit, medical record filing would be improved in 50 per cent of cases.—EDITH FIELD and C. W. MUNGER, M.D.

A PRIMER FOR DIABETIC PATIENTS. *By Russell M. Wilder, M.D. Fifth edition. Philadelphia: W. B. Saunders Company,* 1934. $1.75 and $2.

This is an excellent primer for patients to be used under the guidance of the family doctor. It is designed primarily to help the patient follow the doctor's orders and dietary prescriptions with greater understanding.

Especially to be commended are the prefatory admonition against self-treatment, the refreshing frankness in the discussion of commercial food substitutes and the stress placed upon measures designed to prevent serious complications.

The second half of the primer contains a practical discussion of dietary recipes and substitutions. The entire volume reflects the extensive personal experience of the author with diabetic patients and their problems and for this reason is especially valuable to the doctor.

I recommend this volume with the single reservation that to many patients the "little learning" derived from the use of such a guide may invite self-treatment and confusion. It may be used safely and with profit by intelligent patients.—SOL BILOON, M.D.

NEWS FROM MANUFACTURERS

CHROMOGRAPHS OF SURGICAL PATHOLOGY

This issue of The MODERN HOSPITAL presents the first of an extensive series of color inserts illustrating surgical pathology developed for The Bay Company, Bridgeport, Conn. As will be appreciated from this first plate showing carcinoma of the cervix uteri, the series is designed to provide hospital and surgeons with an educational service of unusual merit.

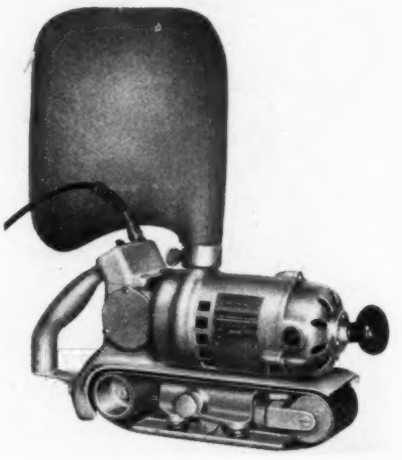
The inserts, which are to run for a number of years, will present in actual color the pathology of instructive surgical cases, the color process plates being made from original drawings by that distinguished artist-anatomist, Tom Jones. Each case presented will be authentic and complete case histories will be available to hospitals. These pictorial records will be approved as to accuracy of anatomy and pathology by a group of distinguished surgeons and pathologists.

Medical directors and superintendents of hospitals will doubtless wish to bring this series of chromographs covering a wide range of surgical pathology to the attention of their medical staff, pathologists, interns and residents and either preserve the plates in a portfolio or frame them for hanging in some appropriate place in the institution.

A DUSTLESS SANDING MACHINE

There are many uses for a sanding machine in hospitals. Such a machine may be used for many kinds of carpenter work, such as repairing furniture and building new pieces of equipment, and for general maintenance work in the institution.

An improved, portable, electrically driven, balanced bench sander for wood, metal, stone and marble sanding applications has just been placed on the market by American Floor Surfacing Machine Co., Toledo, Ohio. The



The sanding machine is a useful picce of equipment in the hospital. The machine shown here is equipped with a dust collector, which is a valuable feature.

American Sanderplane No. 2 is equipped with a dust collector, which is an important feature in hospital work, as it eliminates sanding dust from the air, protects the health of the operator, prevents annoyance to patients and permits cleaning and painting to be done at the same time as sanding.

The American Sanderplane comes equipped either with or without the dust collector. The dust collector is built

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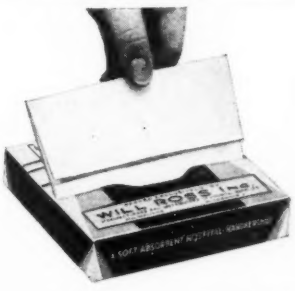
IF you are providing patients with kerchiefs in bulk, loose, or in large boxes, check the percentage actually used and the percentage that goes into waste, unused. When they are placed at the bedside loose, how many are lost through blowing about or careless handling? If patients are given large boxes, how many partially emptied boxes must be destroyed?



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—eliminate waste. They are packed 100 to a box — just the right quantity. Neatness of the package inspires careful use on the part of the patient. And they are vastly more convenient.

Kenwood Folded Kerchiefs have become a regular part of the service in hospitals all over the country. They are preferred in place of cloth or gauze squares for pneumonia cases, ether wipes, post operative tonsil napkins. Soft as old linen, they are also preferred by the patients.

100—5x9 in. sheets (50 double sheets) to the box, 100 boxes to the case.
P-899—Price per case, $5.50
10 case lots, per case, $4.95

WILL ROSS, Inc., Wholesale Hospital Supplies
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NEXT TIME—USE WILTEX

Old style brown pure gum gloves were a great improvement over the first attempts at making surgeons' gloves—

But, WILTEX gloves—of genuine liquid latex —even after 25 sterilizations, have as high a tensile strength as the old style gloves when new and they will normally give from three to five times as much service as old style gloves.

WILTEX
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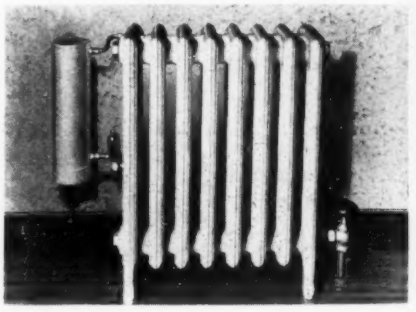
into the machine and is not an attachment with an extra motor. The machine weighs 18½ pounds with the dust collector. It has a rocker type sanding shoe, which permits following irregular surfaces without cutting grooves. The machine is so balanced, it is claimed, that it can be operated with one hand.

The belt size is 3 inches wide by 25 inches long, and the belt speed is approximately 820 feet a minute while the machine is working at maximum capacity. The belt may be quickly changed by tipping the machine on end so that it rests on the forward pulley, which depresses the pulley and locks it in that position.

HUMIDIFIER IS ATTACHED TO RADIATOR

The humidifier shown in the accompanying illustration has been placed on the market to be attached to existing radiators in connection with either steam or hot water heating systems. This attachment is fastened to the end of the radiator so that the heating medium, either steam or hot water, will flow over a coil emersed in water, thus bringing the water near the boiling point and causing vaporization.

Included in the unit is an electrical heating element that can be used as an auxiliary source of heat for vaporization on hot water systems or steam systems when the boiler is operating at low pressure. A cylinder surrounding the coil is filled with water manually and there is an automatic switch to turn off the electrical element should it be working when all the water evaporates.



The humidifier is shown here attached to a radiator. The device is designed for use on either steam or hot water systems.

The unit can be attached by removing two small screw plugs from the end of the radiator and screwing the compression fittings on the humidifier into the two holes that already exist. On old style radiators that do not have the holes which are found on recent models, the humidifier can be attached by tapping two holes in the end of the radiator. American Radiator Company, 40 West Fortieth Street, New York City, is the manufacturer.

CALGONITE—A NEW DISHWASHING AGENT

A new laundering agent, Calgon, developed jointly by the Buromin Company, Pittsburgh, and the Mellon Institute of Industrial Research, was described in this column in November, 1933. Now these two organizations have announced the development of a new cleansing compound for mechanical dishwashing, Calgonite, which eliminates the necessity of wiping and drying glassware, chinaware and aluminum trays, it being noncorrosive to this metal.

Under present day practice, even when dishes are rinsed at a sufficiently high temperature to ensure rapid, spontaneous drying, wiping and drying are ordinarily necessary to avoid "lime stains." Calgonite contains sodium hexametaphosphate, an agent which, it is said, completely sequesters the lime and magnesia content of water and pre-

vents the precipitation of lime soaps and the formation of insoluble films.

Another advantage of Calgonite, it is said, is that it does away with the necessity of deliming and cleaning the washing machine with acid. Although Calgonite is primarily for use in mechanical dishwashing, an allied compound is being developed for the washing of dishes by hand.

Copies of the research report may be secured from the Mellon Institute of Industrial Research.

NEW TRADE CATALOGUES AND PAMPHLETS

Lewis Manufacturing Co.—An attractive booklet is being distributed by Lewis Manufacturing Co., division of The Kendall Company, Walpole, Mass. The booklet is divided into two parts: (1) A brief history of the Curity organization and an interpretation of its aims and purposes, and (2) a complete catalogue section covering Curity dressings and Curity sutures.

Scanlan-Morris Company—"Modern Surgical Lighting," "Maternity Equipment" and "Modern Operating Tables" are the titles of three interesting and attractively arranged booklets that have been issued by Scanlan-Morris Company, Madison, Wis. All three of the booklets have a distinction of typography and illustration.

Troy Engine and Machine Company—Bulletin No. 107 published by Troy Engine and Machine Company, Troy, Pa., describes the company's line of generating sets and tells how stationary plants, such as hospitals, may save with by-product power.

Operay Laboratories, Inc.—Portable and ceiling models of the Surg-O-Ray operating light are described in a folder of Operay Laboratories, Inc., Madison, Wis. The ceiling model is especially designed for use in minor operating rooms and delivery rooms. The company's emergency model light is also described.

E. H. Sargent & Co.—A catalogue of precise polarimetric instruments for analysis and research, produced by the manufacturers of the U. S. Customs House Standard Bates type saccharimeter, which are distributed in the United States by E. H. Sargent & Co., Chicago, has just been issued by the company. The catalogue is attractively arranged and is well illustrated.

Rossville Commercial Alcohol Corporation—A pamphlet "Alcohol Facts" is issued by the Rossville Commercial Alcohol Corporation, Lawrenceburg, Ind. It acquaints laymen with the definitions of ethyl alcohol, pure alcohol, denatured alcohol and U.S.P. alcohol, and is of distinct value for the practical information it gives.

Doehler Metal Furniture Co., Inc.—Literature illustrating furniture items for hospitals is published by the Doehler Metal Furniture Co., Inc., 192 Lexington Avenue, New York City. Included are dressers, chiffoniers, bedside table with removable rubber top, overbed table with three-piece top, reclining easy chair adjustable to four positions, and numerous types of chairs and stools suitable for use in hospitals.

National Live Stock & Meat Board—"Food Value Charts," "Meat and What to Serve With It," and "Meat in the Limited Budget" are among publications released by the National Live Stock & Meat Board, 407 South Dearborn Street, Chicago. Notebook charts for student dietitians and nurses, and wall charts for classrooms are also offered for distribution.